SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM

PROFESSIONAL SERVICES MANUAL

TABLE OF CONTENTS

INTRODUCTION

INTRODUCTION

This manual is one of a series published for the use of medical services providers enrolled in the South Dakota Medical Assistance Program. It is designed to be readily updated by replacement or addition of individual pages as necessary. When such changes occur, **providers will be notified by Remittance Advice. It is important that the provider read the Remittance Advice messages each week for updates**. It is designed to be used as a guide in preparing claims, and is not intended to address all Medical Assistance Program rules and regulations.

Problems or questions regarding Medical Assistance Program rules and policies as well as claims, covered services, and eligibility verification should be directed to:

Department of Social Services
Office of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291
E-Mail: Medical@dss.state.sd.us
PHONE: (605) 773-3495

PROVIDER TOLL FREE NUMBER 1-800-452-7691
***Toll free telephone number is NOT to be given to recipients. This number is only to be used by the provider.**

The telephone service unit will not give out recipient ID numbers. The Medical Assistance Program emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services (other than true emergency services.) It is to the provider's advantage to see the ID card to verify that the recipient is Medical Assistance Program eligible at the time of service, as well as to identify any other program limitations and the listing of the recipient name on the Medical Assistance Program file.

Problems or questions concerning **recipient eligibility requirements** can be addressed by the local field office of the Department of Social Services in your area or can be directed to:

Department of Social Services
Office of Economic Assistance
700 Governors Drive
Pierre, South Dakota 57501-2291
PHONE: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by Medical Assistance Program personnel.

NOTE: If you are not currently submitting claims electronically and are interested in doing so, please contact our office for further information.

CHAPTER 1

GENERAL INFORMATION

The purpose of the Medical Assistance Program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medical Assistance Program was implemented in South Dakota in 1967.

Federal and state governments under Title XIX of the Social Security Act share funding and control of the Medical Assistance Program. Regulations are written to comply with the actions of Congress and the State Legislature.

The following sections provide a description of general information about the program. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing the Medical Assistance Program in ARSD 67:16.

PROVIDER RESPONSIBILITY

ENROLLMENT *AGREEMENT*

A provider who renders a covered service to an eligible South Dakota Medical Assistance Program recipient, and wishes to participate in the Medical Assistance Program must apply to become an enrolled provider. The provider must sign a Provider Agreement with the Department of Social Services. Providers must comply with the terms of participation in the agreement and requirements stated in Administrated Rules of South Dakota (ASRD 67:16) which govern the Medical Assistance Program. Failure to comply with these requirements may result in monetary recovery, and/or civil or criminal action.

Participating providers agree to accept the Medical Assistance Program payment as payment in full for covered services.

An individual (i.e. employee, contractual employee, consultant etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the Medical Assistance Program.

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a seven (7) digit identification number, assigned by the South Dakota Department of Social Services.

TERMINATION – AGREEMENT

When a provider agreement has been terminated the Department of Social Services will not pay for services provided after the termination date. A provider agreement may be terminated for any one of the following reasons:

1. The agreement expires;
2. The provider fails to comply with conditions of participation of the signed provider agreement;
3. The ownership, assets, or control of the provider's entity are sold or transferred;

4. Thirty days have elapsed since the department requested the provider to sign a new provider agreement;
5. The provider has requested termination of the agreement;
6. Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;
7. The provider has been convicted of a criminal offense that involves fraud in any state or federal medical assistance program;
8. The provider is suspended or terminated from participating in Medicare;
9. The provider's license or certification is suspended or revoked; or
10. Due to inactivity.

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity must give the Department of Social Services written notice of the pending sale or transfer at least 30 days before the effective date. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The Medical Assistance Program provider number is NOT transferable to the new owner. The new owner must apply and sign a new provider agreement and a new number must be issued before claims can be submitted.

RECORDS

Providers must keep legible medical and financial records that fully justify and disclose the medical necessity and extent of services provided and billed to the Medical Assistance Program. These records must be retained for at least six years after the last remittance date a claim was paid or denied. Records must not be destroyed when an audit or investigation is being conducted.

Agencies involved in the Medical Assistance Program review or investigation must be granted access to these records.

CLAIM SUBMISSION

The provider must submit the claim to a third-party liability source before submitting it to the Medical Assistance Program with the exception of the following:

1. Prenatal care;
2. EPSDT screening services;
3. Nursing home care; or
4. HCBS Elderly Waiver Service

The claim submitted to the Medical Assistance Program must have the notice of third-party payment or rejection attached to the claim. Failure to attach the notice to each claim may be cause for denial of the claim.

PAYMENTS

Once the provider has identified a third-party source, and, prior to requesting payment from the department, a completed claim for services must be submitted for payment to the third-party source. When the claim is subsequently submitted to the department for payment, evidence of third-party payment or rejection must accompany the claim. The provider is eligible to receive the amount allowed under the department's payment schedule less the third-party liability payment amount.

When the third-party payment equals or exceeds the amount allowed under the Medical Assistance Program, the provider must not seek payment from the recipient, relative, or any legal representative.

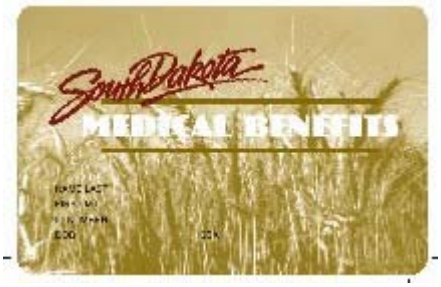
MEDICAL ASSISTANCE PROGRAM RECIPIENT ELIGIBILITY AND POLICIES

The South Dakota Medical Assistance Identification Card is issued by the Department of Social Services on behalf of eligible Medical Assistance Program recipients. The magnetic stripe card has the same background as the Food Stamp EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial and last), the nine digit recipient ID (RID#) plus a three digit generation number, and the recipient's date of birth and sex.

NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on the claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present their Medical Assistance Program identification card to a Medical Assistance Program provider each time, before obtaining a Medical Assistance Program covered service. Failure to present their Medical Assistance Program identification card is cause for payment denial. Payment for denied services becomes the responsibility of the recipient.



Medicaid eligibility verification system (MEVS) offers three ways for a provider to access the state's recipient eligibility file.

- *Point of Service terminal:* (swipe device similar to credit care verification) which maybe purchased or leased.
- *PC Software:* The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- Secure Web based site

All three options provide prompt response times, printable receipts and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through WebMD Envoy.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket' sent to the provider.

Please note that certain Medical Assistance Program recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

**********SD MEDICAID**********
Eligibility
10/19/2004 08:47:25

**********PAYER INFORMATION**********
Payer: SOUTH DAKOTA MEDICAL SERVICES
Payer ID: SD48MED

**********PROVIDER INFORMATION**********
Provider: MID-DAKOTA HOSP
Service Provider #: 9999999

**********SUBSCRIBER INFORMATION**********
Current Trace Number: 200406219999999
Assigning Entity: 9000000000
Insured or subscriber: Mertz, Ethel R.
Member ID: 999999999
Address: Pierre Living Center
2900 N HWY 290
PIERRE, SD 575011019
Date of Birth: 06/21/1908
Gender: Female

**********ELIGIBILITY AND BENEFIT INFORMATION**********
*****HEALTH BENEFIT PLAN COVERAGE*********
ACTIVE COVERAGE
Insurance Type: Medicaid
13
Eligibility Begin Date: 10/19/2004

ACTIVE COVERAGE
Insurance Type: Medicare Primary
13
Eligibility Date Range: 10/19/2004 –
10/19/2004

*****HEALTH BENEFIT PLAN COVERAGE********
*****OTHER OR ADDITIONAL PAYER**********
Insurance Type: Other
Benefit Coord. Date Range: 10/19/2004-
10/19/2004
Payer: BLUE CROSS/BLUE SHIELD
Address: 1601 MADISON
PO BOX 5023
SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #: 999999999

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-760-2804, #536. To add new payers, call 800-215-4730.

CLAIM STIPULATIONS

FORMS
Providers are required to use the National Standard Form (HCFA 1500) to submit claims to the South Dakota Medical Assistance Program.

SUBMISSION
The provider must verify an individual's eligibility before submitting a claim, either through the ID card or in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known, are covered under the South Dakota Medical Assistance Program. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for **medically necessary covered services actually provided** to Medical Assistance Program recipients eligible on the date the service is provided.

TIME LIMITS
The Office of Medical Services must receive a completed claim form within 12 months following the month the service was provided. This time limit may be waived or extended only if one or more of the following situations exist:

1. The claim is a replacement or void of a previously paid claim, and is received within six months after the previously paid claim;
2. The claim is received within six months after a retroactive initial eligibility determination was made as a result of an appeal;
3. The claim is received within six months after a previously denied claim;
4. The claim is received within six months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
5. To correct an error made by the department.

PROCESSING
The Office of Medical Services processes ***paper*** claims submitted by providers in the following manner:

1. Claims and attachments are received by the Office of Medical Services and sorted by claim type and microfilmed;
2. Each claim is given a unique 14-digit **Reference Number.** This number is used to enter, control, and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number.
3. All claims are separately entered into the computer system and will be completely detailed on the Remittance Advice.

To determine the status of a claim, you must reconcile your files with the information on the Remittance Advice.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of Medical Assistance Program recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under 42CFR 456.3, the Medical Assistance Program is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of Medical Assistance Program services or excess payments, and assesses the quality of those services. 42CFR 456.23 authorizes a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers.

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by the Medical Assistance Program.

FRAUD AND ABUSE

The SURS Unit is responsible for the identification of possible fraud and/or abuse. The Medicaid Fraud Control Unit (MFCU) under the Office of the Attorney General, is certified by the Federal Government to detect, investigate, and prosecute any fraudulent practices or abuse against the Medical Assistance Program. Civil or criminal action or suspension from participation in the Medical Assistance Program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits of Payments from Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and Administrative Rule of South Dakota (ARSD) 67:16.

DISCRIMINATION PROHIBITED

South Dakota Medical Assistance Program, participating medical providers, and contractors may not discriminate against Medical Assistance Program recipients on the basis of race, color, national origin, religion, age, sex or disability. All enrolled Medical Assistance Program providers must comply with this non-discrimination policy.

MEDICALLY NECESSARY

Medical Assistance Program covered services are to be payable under the Medical Assistance Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions:

1. It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
2. It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
3. It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
4. It is not furnished primarily for the convenience of the recipient or the provider; and
5. There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

CHAPTER II

PHYSICIAN SERVICES

COVERED SERVICES

Covered physician services are limited to the following professional services which must be medically necessary and provided by a physician to a recipient:

1. Medical and surgical services;
2. Services and supplies furnished incidental to the professional services of a physician;
3. Psychiatric services;
4. Drugs and biologicals administered in a physician's office which cannot be self-administered;
5. Routine physical examinations;
6. Routine visits to a nursing facility, a home and community-based service or waiver service provider, an intermediate care facility for the mentally retarded or developmentally disabled;
7. Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member;
8. Family planning services;
9. Pap smears;
10. Dialysis treatments;
11. Hysterectomies authorized under 42 C.F.R. 441.250 to 441.259, inclusive (October 1, 1989);
12. Hyperbaric oxygen therapy if the requirements of Administrative Rule of South Dakota (ARSD) 67:16:02:05.08 and 67:16:02:05.09 are met; and
13. Diabetic education as defined in Administrative Rule of South Dakota (ARSD) 67:16:46.

OTHER COVERED HEALTH SERVICES

Other medically necessary health services and supplies covered under the program are limited to the following:

1. X-rays for diagnostic and treatment purposes;
2. Laboratory tests for diagnostic and treatment purposes;
3. Prior authorization of prosthetic devices, artificial limbs, artificial eyes, augmentative communication devices, items to replace all or part of an internal body organ, and the replacement of such devices required by a change in the patient's condition;
4. X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
5. Surgical dressings following surgery;
6. Splints, casts, and similar devices;
7. Supplies necessary for the use of prosthetic devices or medical equipment payable under the provisions of Administrative Rule of South Dakota (ARSD) 67:16:29;
8. Hearing aids, subject to the limits and payment provisions established in Administrative Rule of South Dakota (ARSD) 67:16:29; and
9. Services of hospital-based physicians.

NON COVERED HEALTH SERVICES

In addition to the services not specifically listed in Administrative Rule of South Dakota (ARSD) 67:16:02:05, the following health services and items are not covered under the Medical Assistance Program:

1. Medical equipment for a resident in a nursing facility or an intermediate care facility for the mentally retarded or developmentally disabled;
2. Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment, including air conditioners, humidifiers, dehumidifiers, heaters, and furnaces;
3. Gastric bypass, gastric stapling, gastroplasty, any similar surgical procedure, or any weight loss program or activity;
4. Agents to promote fertility;
5. Procedures to reverse a previous sterilization;
6. Removal of implanted contraceptive capsules if done to reverse the intent of the original implant; and
7. Occupational therapy services are not a covered service unless specified in chapter 67:16:03, chapter 67:16:11, and 67:16:37 of ARSD.

AUDIOLOGICAL TESTING AND SPEECH PATHOLOGY SERVICES

Services are covered for audiological testing and speech pathology services when provided by a physician, a clinical audiologist, or a speech pathologist unless the services are a part of a child's individual education plan (IEP) or individual family service plan (IFSP). These services are the responsibility of the School District under ARSD 67:16:37:14.

Speech therapy services or audiology services must be provided by a speech pathologist or an audiologist, who has a certificate of clinical competence from the American Speech Hearing Association. The provider must have completed the equivalent educational requirements and work experience necessary for the certification, or have completed an academic program and be acquiring supervised work experience to qualify for the certification.

Covered services are limited to those services provided by a physician or by the audiologist or speech pathologist when the patient has a written referral from a physician and when the services are necessary to diagnose or treat a medical problem.

NOTE: Information relating to certification as a clinical audiologist or speech pathologist may be obtained from the American Speech and Hearing Association, 10801 Rockville Pike, Rockville, Maryland 20852.

PHYSICAL THERAPY SERVICES

Physical therapy services, which are ordered by a physician through a written prescription and provided by a licensed physical therapist, are covered services under this article.

EXCEPTION: When the services are a part of a child's individual education plan (IEP) with a school district or the child has been determined to be **prolonged assistance** by the State's Department of Education, the services become the responsibility of the School District in which the child is enrolled, and coverage falls under school district ARSD 67:16:37.

REFRACTION AND EYEGLASSES

Payable physician services relating to refractions and the provision of eyeglasses are subject to the limits established in ARSD 67:16:08.

BREAST REDUCTION

Surgery to reduce the size of the breast **must be prior authorized by the department.** The authorization is based on documentation submitted to the department by the physician. The documentation **must** substantiate the existence of the following conditions:

1. The breasts are so large they extend down to at least the level of the antecubital fossae (elbow);
2. The breasts are so large and heavy they cause frequent backache;
3. Supporting bra straps cut into the skin of the shoulders, with possible subcutaneous fat necrosis;
4. Significant interference with activities of daily living; and
5. If the individual is obese, evidence that weight reduction has not reduced or would not reduce the symptoms described in this section.

STERILIZATION

Payment for sterilization is limited to those procedures performed on a recipient who meets the following criteria;

1. Is at least 21 years old;
2. Is a legally competent individual;
3. Has signed an informed consent form after the recipient's 21st birthday; and
4. At least 30 days but not more than 180 days have passed between the date the informed consent form was signed and the date of the sterilization.

In the case of a premature delivery, subdivision (4) of this section may be waived if the informed consent form was signed at least 30 days before the expected delivery date and if at least 72 hours have passed between the time the informed consent form was signed and the time of the delivery.

In the case of emergency abdominal surgery, subdivision (4) of this section may be waived if the informed consent form was signed at least 72 hours before the emergency surgery was performed.

CONSENT FORM

Federal regulations control the requirements which enable the state to receive federal matching funds for sterilizations and hysterectomies.

The federal regulations must be met in order for the state to receive federal funds. The state Medical Assistance Program office will deny payment to physicians, hospitals, surgi-clinics, anesthesiologists, nurse anesthetists, or any provider billing for services involving sterilization or hysterectomy unless the Consent Form for Sterilization or Acknowledgment of Information for Hysterectomy form are in compliance.

The Medical Assistance Program sterilization consent form must be accurately completed and attached to the claim. An example of the form and the instructions for completing the form are as follows:

INFORMED CONSENT

Informed consent consists of the following:

1. Providing a copy of the consent form to the individual to be sterilized;
2. Offering to answer any questions the individual has about sterilization;
3. Giving the following information to the person to be sterilized;
    a. That they may withdraw their consent at any time prior to sterilization and that the withdrawal will not affect any program benefits.
    b. A description of alternative methods of birth control;
    c. That the procedure is considered to be irreversible;
    d. An explanation of the sterilization procedure to be performed;
    e. An explanation of discomforts and risks of the sterilization procedure, including anesthetic risks;
    f. A full description of the benefits that may be expected; and
    g. That sterilization cannot be performed for at least 30 days except for circumstances listed under “Exceptions”.
4. Arrangements shall be made to effectively inform the blind, deaf, and those who do not understand the language.

Informed consent is not to be obtained while the individual is:

1. In labor or child birth;
2. Seeking to obtain or obtaining an abortion; or
3. Under the influence of alcohol or drugs.

EXCEPTIONS: In the event of a premature delivery, the following must occur:

1. The consent form must be signed by the individual to be sterilized at least 30 days prior to expected delivery date and at least 72 hours prior to the sterilization;
2. The date of the expected delivery must be written on the consent form;

In the event a sterilization is performed during an emergency abdominal surgery, the following must occur:

1. The consent form must be signed by the individual to be sterilized at least 72 hours prior to sterilization;
2. The physician must describe the surgery and explain the medical necessity of the emergency abdominal surgery.

CONSENT FORM INSTRUCTIONS

The consent form must be signed by the recipient **at least 30 days** and no more than 180 days prior to sterilization surgery.

CONSENT

1. Doctor’s or clinic’s name;
2. Name of surgery;
3. Month, day, and year of the (recipient’s) birth;
4. Recipient’s name;
5. Name of the doctor who will be performing the surgery;
6. Name of the surgery(same as #2 above);
7. Recipient’s signature; and
8. Month, day and year the recipient signed the form.

INTERPRETER'S STATEMENT

This section must be fully completed whenever the recipient being sterilized cannot fully understand or speak English:

1. The recipient's native language; and
2. Signature of the interpreter and the date the information was provided.

STATEMENT OF PERSON OBTAINING CONSENT

1. Name of the individual requesting the sterilization;
2. Name of the surgery to be performed (same as #2);
3. Signature of the person obtaining the consent and witnessing the recipient's signature and the date consent was obtained (the date should be the same as #8);
4. Name of the facility or agency the individual represents; and
5. Mailing address of the facility or agency.

PHYSICIAN'S STATEMENT

1. Name of recipient;
2. Date of surgery (must be 30 days or more after #8);
3. Name of surgery performed (same as #2);
4. Signature of physician who performed the surgery; and
5. Date of physician's signature (this signature must be after the surgery is completed).

NOTE: A copy of the consent form must be attached to all sterilization claims submitted to the Medical Assistance Program.

DSS-MS-146 (Revised 11/89)

MEDICAID STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAM OF PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____. When I first asked for the
(*Doctor or Clinic)*
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.
I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.
I am at least 21 years of age and was born on _____
Month/Day/Year
I, _____, hereby consent of my own free will to be sterilized by _____ by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare,
or
Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.
I have received a copy of this form.

_____ Date:_____
Signature *Month/Day/Year*

You are requested to supply the following information, but it is not required:
Race and ethnicity designation (please check)

☐ American Indian or Alaska Native
☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin)
☐ Hispanic
☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
Name of Individual
consent form. I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risk, and benefits associated with it.
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that serialization is different because it is permanent.
I informed the individual to be sterilized that his/her consent can be withdrawn at any and that he/she will not lose any health services or any benefits provided by Federal funds.
To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____,
Name of individual to be sterilized *Date of sterilization*
I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.
I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.
To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.
(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)
(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery

☐ Individual's expected date of delivery:

☐ Emergency abdominal surgery:
(describe circumstances):

_____
Physician
Date_____

ATTACH THE PROPERLY COMPLETED FORM TO MEDICAID CLAIMS RELATIVE TO STERLIZATIONS.

HYSTERECTOMY

The federal regulation for hysterectomy requires that the recipient has been informed that the hysterectomy will render the individual permanently incapable of reproducing. The recipient must sign a statement acknowledging receipt of infertility information prior to surgery. Most hospital operative permits **DO NOT** meet the federal requirements for hysterectomy information.

SPECIAL CONSIDERATIONS

If the woman was sterile **prior to** the hysterectomy you must have the recipient sign the Acknowledgment of Information form, the physician may write a statement that the recipient was sterile prior to the hysterectomy and the reason for the sterility. The statement must be signed and dated by the physician and the statement must be attached to the claim.

When a recipient requires a hysterectomy due to a life threatening emergency, and the physician determines that **prior acknowledgment is not possible** the physician must certify in writing that the hysterectomy was performed under a life-threatening emergency in which he or she determined prior acknowledgment was not possible. The physician must also include a description of the nature of the emergency. This statement, signed and dated by the physician, must be attached to the claim.

NOTE: DO NOT USE A STERILIZATION CONSENT FORM FOR A HYSTERECTOMY.

INTERPRETER'S STATEMENT

This section must be completed whenever the recipient cannot fully understand or speak English.

1. Name of the recipient's native language.
2. Signature of the interpreter and the date the information was provided.

NON-COVERED STERILIZATION AND HYSTERECTOMY SERVICES

The Medical Assistance Program does not reimburse for the following:

1. Hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing;
2. Sterilization of a mentally incompetent individual;
3. Sterilization of an institutionalized individual;
4. Sterilization of an individual who has not reached his or her 21st birthday when the sterilization consent form is signed;
5. Sterilization or hysterectomy when the consent form is not completed, is not accurate, or is not legible; or
6. When the consent form or Acknowledgment of Information was signed more than 180 days prior to surgery

DEPARTMENT OF SOCIAL SERVICES

MEDICAL SERVICES

ACKNOWLEDGEMENT OF INFORMATION FOR HYSTERECTOMY

Prior to having a hysterectomy, I understand/understood and fully acknowledge that the Surgical procedure of hysterectomy renders me permanently sterile.

_____ _____

Date Signature

If an interpreter is provided to assist the individual on whom the hysterectomy is being performed:

- **INTERPRETER'S STATEMENT**

I have translated the information and advice presented orally to the individual who is receiving a hysterectomy by the person obtaining this consent. I have also read to her, the consent form in _____ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

_____

Interpreter Date

The Medicaid recipient <u>must sign</u> and date the Acknowledge of Information form prior to Medicaid payment.

TELEMEDICINE CONSULTATION SERVICES

Telemedicine is the real time or near real time two-way transfer of medical data and information between two medical entities.

Medical data exchange can take the form of multiple formats: text, graphics, still images, audio, and video. The information/data exchange can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (ascynchronous) through so-called store and forward applications such as electronic mail, fax, or phone-mail.

Telemedicine services provided to eligible South Dakota Medical Assistance Program recipients are limited to consultation services, follow up office visits for established patients, and pharmacological management services. Coverage of telemedicine consultations is treated like any other consultation service as defined in the Physician's Current Procedural Terminology (CPT).

When an attending physician requests an opinion or advice regarding evaluation and/or management of a specific problem from another physician or appropriate source, the consultant may bill the appropriate evaluation/management code for the service to the South Dakota Medical Assistance Program.

Appropriate CPT codes for these consultation services are within the CPT range of 99241-99275. When billing the South Dakota Medical Assistance Program for telemedicine consultations the addition of the procedure code modifier "GQ", or "GT" is required. The "GQ" modifier denotes asynchronous telecommunications system. The "GT" signifies interactive audio and video telecommunications systems.

The South Dakota Medical Assistance Program also reimburses telemedicine technology services for follow-up visits of established patients. Specifically, reimbursement for follow-up visits for established patients delivered via telemedicine are limited to CPT evaluation and management procedure code range 99211-99215. Additionally, telepsychiatric services are reimbursed and are limited to pharmacological management – procedure coder 90862.

The reimbursement for the cost incurred from the use of the telemedicine network is included in Medical Assistance Program's payment for the evaluation/management code submitted by the requesting physician. It is not appropriate to bill the South Dakota Medical Assistance Program for telemedicine network costs under any additional CPT code.

HYPERBARIC OXYGEN THERAPY

REQUIREMENTS – ADMINISTRATIVE RULE 67:16:02:05.08

Hyperbaric oxygen therapy is a modality in which the entire body is placed in a chamber and exposed to oxygen under increased atmospheric pressure. The department must authorize hyperbaric oxygen therapy before it is provided. Hyperbaric oxygen therapy is limited to outpatient services for treatment of the following conditions:

1. Acute carbon monoxide intoxication;
2. Decompression illness;
3. Gas embolism;
4. Gas gangrene;

5. Acute traumatic peripheral ischemia. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life threatened;
6. Crush injuries and suturing of severed limbs. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
7. Meleney ulcers. Any other type of cutaneous ulcer is not covered;
8. Acute peripheral arterial insufficiency;
9. Preparation and preservation of compromised skin grafts;
10. Chronic refractory osteomyelitis which is unresponsive to conventional medical and surgical management;
11. Osteoradionecrosis as an adjunct to conventional treatment;
12. Soft tissue radionecrosis as an adjunct to conventional treatment;
13. Cyanide poisoning;
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; or
15. Diabetic wounds of the lower extremities in patients who meet the criteria in ARSD 67:16:02:05.08.

PRIOR AUTHORIZATION – ADMINISTRATIVE RULE OF SOUTH DAKOTA (ARSD) 67:16:05.09

A physician must have authorization from the department before providing hyperbaric oxygen therapy. To obtain authorization, the physician must submit a prior authorization request with supporting documentation. The department shall determine whether the therapy is eligible for reimbursement. The department may verbally authorize the therapy after the request is submitted; however, the department must verify the verbal authorization in writing before the claim is paid.

An authorization may not exceed two months. A physician may request reauthorization by submitting an updated request indicating the need for the continued therapy.

RATE OF PAYMENT

A claim submitted must be submitted at the physician's usual and customary charge. Payment is limited to the lesser of the physician's usual and customary charge or the fee established under the following provisions:

> **NOTE:** The below Appendix's are located within Administrative Rule Physician 67:16:02 located at the end of this manual.

1. For nonlaboratory procedures listed in Appendix A, the amount specified in Appendix A;
2. For nonlaboratory procedures not listed in Appendix A but listed in Appendix C the amount specified in Appendix C;
3. For nonlaboratory procedures not listed in either Appendix A or Appendix C, 40 percent of the physician's usual and customary charge;
4. For laboratory procedures listed in Appendix B, the amount specified in Appendix B;
5. For laboratory procedures not listed in Appendix B, 60 percent of the physician's usual and customary charge;
6. For anesthesia services furnished by a physician time must be reported in 15-minute units beginning from the time the physician begins to prepare the patient for induction

and ending when the patient is placed under postoperative supervision and the physician is no longer in personal attendance; reimbursement is $16 for each unit. Base units are included in the CPT code.

7. For anesthesia services furnished by a nurse anesthetist, $16 for each unit computed according to subdivision (6) of this section as long as the anesthetist is assisting the physician in the care of a Medical Assistance Program patient;
8. For medical supplies incidental to the professional service provided, the fee allowed by Medicare is listed in Appendix C the amount specified in Appendix C. If the medical supplies are not 90 percent of the physician's usual and customary charge listed in Appendix C, 90 percent of the physician's usual and customary charge;
9. For injection and immunization procedures found in Appendix A, the amount specified in Appendix A. For injections and immunization procedures found in Appendix C, the amount specified in Appendix C. If the procedures are not listed in Appendix A or C, 40 percent of the physician's usual and customary charge; and
10. For prosthetic or orthotic devices or medical equipment provided by a physician, the fee allowed by Medicare is listed in Appendix C. If the devise is not listed in Appendix C, 75 percent of the physician's usual and customary charge.

BILLING REQUIREMENTS

IMPLANTABLE CONTRACEPTIVE CAPSULES

A claim for covered implantable contraceptive capsules and obstetrical services must be submitted at the provider's usual and customary charge and is limited to procedure codes listed in Appendix A of Administrative Rule 67:16:02 and 67:16:12.
The kit for insertion or reinsertion of an implantable contraceptive capsule must be billed separately on submitted claims.

OBSTETRICAL SERVICES

A claim submitted using a global delivery procedure code of 59400 or 59510 is allowed only if the provider has provided six or more antepartum visits to the recipient. A provider may not submit separate claims for the antepartum care, delivery services, or postpartum care when using either of the global delivery codes.

A claim submitted for postpartum care is limited to hospital and office visits in the 30 days following vaginal or cesarean section delivery.

REIMBURSEMENT

A claim must be submitted at the provider's usual and customary charge.

Claims submitted for the services of a physician must be for services provided by the participating physician or an employee who is under the direct supervision of the participating physician.

The laboratory that actually performed the laboratory test must submit the claim for the test.

When relevant, the claim shall identify the modifying circumstance of a service or procedure by the addition of the applicable modifier code to the procedure code. Modifier codes are located below in Basis of Reimbursement.

Claims submitted for multiple surgeries must contain the applicable procedure code for the primary surgical procedure. All other procedures performed during the same operating session must be billed using the applicable procedure code plus the two-digit modifier of 51. A bilateral procedure or a surgical procedure which cannot stand alone, but which is performed as a part of a primary surgical procedure, such as procedure code 15261, is not considered a multiple surgical procedure.

Claims submitted by a nurse practitioner or a physician assistant must contain the nurse practitioner's or the physician assistant's provider identification number and may not be submitted under the supervising physician's provider identification number.

MODIFIER CODES

Services and procedure codes must be modified under certain circumstances. Modifier codes must be used when applicable. Payment for services listed with one or more modifier codes is limited to the lesser of the physician's usual and customary charge or the payment established according to the following:

-22 Unusual services. When the service provided is greater than that usually required for the listed procedure, it must be identified by adding modifier "-22" to the usual procedure code. A report may be appropriate.

-26 Professional component. Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service must be identified by adding the modifier "-26" to the usual procedure code.

-47 Base units for anesthesia given by a surgeon

-50 Bilateral procedure. Unless otherwise identified in this listing, bilateral procedures requiring a separate incision that are performed at the same operative session must be identified by the applicable five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier "-50" to the procedure code.

-51 Multiple procedures. When multiple procedures are performed on the same day or at the same session, the major procedure or service must be reported as listed. The secondary, additional, or lesser procedure or service must be identified by adding the modifier "-51" to the secondary procedure or service code. This modifier must be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical procedures or several surgical procedures performed at the same operative session. Bilateral procedures and surgical procedures which cannot stand alone but which are performed as a part of a primary surgical procedure, such as procedure code 15261, are not considered multiple medical procedures and may not be reported with a "-51" modifier.

-52 Reduced services. Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided must be identified by its usual procedure code and the addition of the modifier "-52" signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

-54 Surgical care only. When one physician performs a surgical procedure and one or more other physicians provide preoperative or postoperative management, surgical services must be identified by adding the modifier "-54" to the usual procedure code.

-55 Postoperative management only. When one physician performs the postoperative management and another physician performs the surgical procedure, the postoperative component must be identified by adding the modifier "-55" to the usual procedure code.

-56 Preoperative management only. When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component must be identified by adding the modifier "-56" to the usual procedure code.

-59 Distinct Procedural Service.

-75 Concurrent care

-80 Assistant surgeon. Surgical assistant services must be identified by adding the modifier "-80" to the usual procedure code.

-81 Minimum assistant surgeon. Minimum surgical assistant services must be identified by adding the modifier "-81" to the usual procedure code.

-82 Assistant surgeon when qualified resident surgeon not available. The unavailability of a qualified resident surgeon is a prerequisite for use of modifier "-82" appended to the usual procedure code.

-TC Technical component.

ET Emergency Service

-EY No physician or other licensed health care provider order for this item or service. Emergency services, no MD order fro item/service.

-F1 Left hand, second digit.

-F2 Left hand, third digit.

-F3 Left hand, fourth digit.

-F4 Left hand, fifth digit

-F5 Right hand, thumb.

-F6 Right hand, second digit.

-F7 Right hand, third digit.

-F8 Right hand, fourth digit.

-F9 Right hand, fifth digit.

-FA Left hand, thumb.

-GM Multiple patients on one ambulance trip.

-GQ Via asynchronous telecommunications system. Telehealth store and forward.

-GT Via interactive audio and video telecommunication systems. Interactive Telecommunication

-HA Child/adolescent program

-HB Adult program, non geriatric

-HC Adult program geriatric

-HD Pregnant/Parenting women's program

-HE Mental health program

-HF Substance abuse program

-HH Integrated Mental Health/Substance Abuse Program

-HK Specialized Mental Health Program for High-Risk Populations

-HQ Group setting

-HZ Funded by criminal justice agency

-LT Left body side procedure

-NR New when rented (use the 'NR' modifier when DME which was new at the time of rental is subsequently purchased)

-NU New equipment

-RP Placement and repair (DME)

-RR Rental (use the 'RR' modifier when DME is to be rented). Rental (DME)

-RT Right body side procedure

SA Nurse Practitioner Rendering Service with A Physician

SC Medically Necessary Service or Supply

SE State and/or Federally-Funded Programs/Services

-T1 Left foot, second digit

-T2 Left foot, third digit

-T3 Left foot, fourth digit

-T4 Left foot, fifth digit

-T5 Right foot, great toe

-T6 Right foot, second digit

-T7 Right foot, third digit

-T8 Right foot, fourth digit

-T9 Right foot, fifth digit

-TA Left foot, great toe

-TD RN

-TE LPN/LVN

-TK Extra patient or passenger, non-ambulance

-TL Early Intervention/Individualized Family Service Plan (IFSP)

-TN Rural/outside providers' customary service area

-U1 Medicaid level of care1, defined by each state

-U2 Medicaid level of care2, defined by each state

-U3 Medicaid level of care3, defined by each state

-U4 Medicaid level of care4, defined by each state

-U5 Hospital transfer, more than one person, out of city, per person

-U6 One trip one person **in** city

-U7 One trip more than one person **in** city, per person

-U8 One trip one person **out** of city

-U9 One trip more than one person, **out** of city per person

-UE Used durable medical equipment.

REIMBURSEMENT FOR MULTIPLE SURGERIES

Payment for multiple surgical procedures performed during the same operative session is limited to the lesser of the provider's usual and customary charge or the amount specified in the following:

1. Full reimbursement may be allowed for the primary surgical procedure and for a surgical procedure which cannot stand alone but which is performed as a part of a primary surgical procedure. All other procedures, except for bilateral procedures, performed during the same operative session require the use of the modifier code of 51 and are payable under the provisions of subdivision (3) of this section.
2. For surgical procedures using a two-digit modifier of 50 (bilateral procedure), 50 percent of the fee specified in Appendix A or C of the rules or, if no fee is listed, 40 percent of the physician's usual and customary charge.
3. For secondary surgical procedures using a modifier of 51 (multiple procedures performed on the same day), 50 percent of the fee specified in Appendix A or C or, if no fee is listed, 30 percent of the physician's usual and customary charge.
4. No reimbursement may be allowed for surgical procedures that are incidental to the primary procedure, as determined by the department.

REIMBURSEMENT FOR SERVICES PROVIDED BY NURSE MIDWIFE OR NURSE ANESTHETIST – Administrative Rule of South Dakota (ARSD) 67:16:02:14

Services provided by a nurse midwife or a nurse anesthetist shall be reimbursed at the same rate as if a physician provided the service.

REIMBURSEMENT FOR SERVICES PROVIDED BY NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT – ARSD 67:16:02:15

Except for laboratory services, radiological services, immunizations, and supplies, services provided by a nurse practitioner or a physician's assistant are reimbursed at 90 percent of the physician's fee established under this chapter.

Reimbursement for laboratory services, radiological services, immunizations, and supplies provided by a nurse practitioner or a physician's assistant are reimbursed according to ARSD 67:16:02:03.

CHAPTER III

AMBULATORY SURGERY CENTER (ASC)

PROVIDER REQUIREMENTS

To provide services listed in this Chapter, the facility:

1. Must **not** be a hospital; and
2. Must be approved by Medicare as an Ambulatory Surgical Center.

LIMITS – COVERED SERVICES

Ambulatory Surgical Center (ASC) services are limited to only those procedures listed Administrative Rule of South Dakota (ARSD) 67:16:28, Appendix A. Included in the payment of these procedures are services such as:

1. Nursing, technician, and related services;
2. Use of ASC facilities;
3. Drugs, biologicals, surgical dressing, supplies, splints, casts, appliances and equipment directly related to the provision of surgical procedures;
4. Diagnostic or therapeutic services or items directly related to the provision of surgical procedure;
5. Administrative and recordkeeping services;
6. Housekeeping items and supplies; and
7. Materials for anesthesia.

MODIFIER CODES

To properly identify multiple surgeries you will need to add a modifier code **51** to the end of the procedure code. **Procedures which are considered incidental to the primary procedure are not allowed reimbursement**. On your claim you will list the five digit primary procedure code (the highest grouper) without a modifier code.

Additional surgeries performed in a single operative session must be listed with the five digit procedure code **plus the modifier code 51.** Additional surgeries include bilateral procedures; separate procedures through the same incision; or separate procedures through different incisions. Payment for the procedures are as follows:

EXAMPLE: 7/6/04 69436 (this would be paid at 100% of grouper)
7/6/04 69436-51 (this would be paid at 50% of grouper)

NOTE: Failure to properly report multiple surgeries by using the modifier code will cause these lines to be denied payment because the service is an exact duplicate of another line.

DO NOT LIST MORE THAN ONE SURGERY PROCEDURE PER DATE OF SERVICE WITHOUT USING A MODIFIER CODE.

CHAPTER IV

CHIROPRACTIC SERVICES

COVERED SERVICES AND PROCEDURE CODES

PROGRAM REQUIREMENTS

The following requirements must be met before the Medical Assistance Program can reimburse a provider for covered chiropractic services:

The diagnosis must be subluxation of the spine. **Only the following diagnosis codes are acceptable:**

749.0	839.00 to 839.08, inclusive
739.1	839.20
739.2	839.21
739.3	839.40 to 839.42, inclusive
739.4	
739.5	

X-rays must substantiate the subluxation. A claim for the x-ray(s) must be submitted to the department within 12 months preceding the service.

NOTE: These requirements do not prohibit taking additional x-rays when necessary due to an injury, accident, or change in the recipient's condition.

RESTRICTIONS:

The Medical Assistance Program pays for a maximum of 30 manual manipulations of the spine in a 12 month period. The date of the first manipulation is the start date of the continuing 12-month period.

An initial office visit must be billed only once for each recipient unless the recipient was last seen 3 years previous.

LIMITS – COVERED SERVICES:

Chiropractic services are limited to only those procedures listed below when the diagnosis is for subluxation of the spine.

PROCEDURE CODES

Payment for chiropractic services is limited to the lesser of the provider's usual and customary charge or the fee contained in ARSD 67:16:09:05.01.

CODE	PROCEDURE
98940	CMT, spinal 1 – 2 regions
98941	CMT. Spinal 3 – 4 regions

98942	CMT, spinal 5 regions
72010	X-ray exam of spine, entire
72020	X-ray of spine single view
72040	X-ray exam of neck spine
72070	X-ray of chest spine
72072	Radiological exam spine thoracic
72080	X-ray exam spine 3 view
72100	X-ray exam lower spine lateral
99201	Office visit new patient
99211	Office visit established patient

A provider may not bill multiple units of procedure code 72020 if a multiple-view procedure code is applicable. The number of units indicates the number of times a procedure is performed, not the number of views.

A provider may not submit a claim for procedure code 99211 in conjunction with procedure code 99201. A provider may not submit a claim for procedure code 99211 more than once in three years. A provider may not submit a claim for procedure code 99201 or 99211 unless it is the provider's customary to charge the general public for these services.

NOTE: Because Medicare does not reimburse for radiologic procedures, you DO NOT need to submit your claim to Medicare prior to submitting the radiologic service to the Medical Assistance Program.

CHAPTER V

DURABLE MEDICAL EQUIPMENT

COVERED SERVICES

PROGRAM REQUIREMENTS

Durable medical equipment is covered only when all of the following requirements are met:

1. The equipment must be medically necessary according to Administrative Rule of South Dakota (ARSD) 67:16:01:06.02;
2. The equipment must be prescribed in writing by a physician for use in the recipient's residence. A recipient's residence does not include a nursing facility, an intermediate care facility for the mentally retarded, or an institution for individuals with a mental disease;
3. The prescription must be signed and dated by the physician before the covered medical equipment is provided. The effective date of the prescription is the physician's signature date;
4. The physician must complete, sign and date a Certificate Of Medical Necessity (CMN) as contained in Appendix E of ARSD 67:16:29, within 30 days after the date of the prescription. The medical equipment provider must maintain the CMN in the recipient's clinical record. Failure to obtain or maintain a properly completed CMN is cause for nonpayment;
5. When equipment is rented, the CMN must be renewed every six months. A prescription is required only for the initial six month rental period. Subsequent CMNs must be signed and dated by the prescribing physician no later than 30 days after the end of the previous six month rental period. Documentation justifying continued use of rental equipment must be contained in the CMN;
6. Medicare CMNs will be accepted for Medicare/Medical Assistance eligible recipients;
7. The equipment is shown as being covered on the Medical Equipment Covered Services list;
8. Equipment that does not appear on the list of Medical Equipment Covered Services must be prior authorized before being provided to a child under the EPSDT program.

MEDICAL EQUIPMENT COVERED SERVICES

Covered medical equipment is limited to the list contained in ARSD 67:16:29:02. Specific requirements or restrictions can be found in ARSD 67:16:29.

NOTE: A claim for hearing aids may not be submitted until after 30 days of placement. A claim may not be submitted if the hearing aids are returned during a trial period.

MODIFIER CODES

To identify certain equipment properly you will need to add a modifier code to the end of the procedure code. The following modifier codes should be used as appropriate:

LL – Lease/rental (when rental is to be applied to the purchase price-12 monthly rental payments);

NU – New Equipment;

RP – Replacement or repair;

RR – Rental (when medical equipment is to be rented); or

UE – Used medical equipment.

CERTIFICATE OF MEDICAL NECESSITY REQUIREMENTS

1. The CMN form contained in ARSD 67:16:29 Appendix E must be used. Providers may transpose their letterhead on to the form itself, however, the remainder of the form must be used intact.
2. The prescribing physician must complete, sign, and date the CMN. The equipment provider must complete the portion of the form that relates to the equipment function, cost and rental price, and equipment provider information. The equipment is to be described and the equipment provider must include their provider number, name, address, and the name of the provider's contact person.
3. The recipient's diagnosis AND the specific medical condition that necessitates the need for the equipment or supply must be identified on the CMN. Also required is the prognosis or anticipated outcome of the medical condition. A timeframe of how long the medical condition is expected to be present should be indicated by entering a number in the months blank or a checkmark in the indefinite or permanent blank. Justification is needed as to why and for how long the equipment is to be rented.
4. An explanation of the medical need for the equipment is required and must include how the equipment will relieve, correct, or treat the medical condition. If supplies are being provided, the equipment that the supplies are used with must be indicated.
5. A statement indicating the equipment is to be purchased instead of rented must be present. The purchase price for the equipment must be given. This amount should be the amount on the equipment supplier's invoice less discounts (the actual cost to the equipment provider as reflected on the invoice). The provider's rental price per day, week, month, or year is also required. This information is vital for providers and the program in determining the cost effectiveness of purchase or rental of the equipment.
6. The EPSDT CMN requires an additional explanation of equipment not covered under the Medical Equipment Chapter to determine the potential for coverage under the children's program. Equipment for children under 21 years of age that is not listed as a covered item in the rules is reviewed on a case-by-case basis to determine coverage.

CHAPTER VI

EPSDT SCREENING SERVICES AND PERIODICITY SCHEDULES

PURPOSE OF EPSDT

Early Periodic Screening, Diagnosis and Treatment (EPSDT) services are targeted at all federally mandated Medical Assistance clients age 20 and under. EPSDT is a federally mandated service under the South Dakota Medical Assistance Program. In effect, EPSDT is a partnership between the provider and the Medical Assistance Program.

A comprehensive child health program, EPSDT consists of two, mutually supportive operational components:

- Facilitating the availability and accessibility of required health care resources; and
- Helping Medical Assistance recipients and their parents or guardians to effectively use them.

These components enable Medical Assistance to manage a comprehensive child health program of prevention and treatment, to systematically:

- Seek out eligible participants and inform them of the benefits of prevention and the health services and assistance available;
- Help them and their families use resources, including their own talents and knowledge, effectively and efficiently;
- Assess the child's health needs through initial and periodic examinations and evaluation; and
- Assist health care providers to diagnose and treat health problems early, before they become more complex and their treatment more costly.

This concept has been recognized as a means of increasing program efficiency and effectiveness with the expectation that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided.

SCREENING SERVICES

Providers are to conduct well child checkups and immunizations according to a periodicity schedule established by the American Academy of Pediatrics and other care experts. See *Recommended Childhood Screening and Immunization Schedule* below.

Suggested Checkup Schedules	
Suggested Medical Checkups Birth up to 1 Week 1 Week up to 6 Weeks 6 Weeks up to 3 Months 3 Months up to 5 Months 5 Months up to 8 Months 8 Months up to 11 Months 11 Months up to 14 Months 14 Months up to 17 Months 17 Months up to 20 Months 20 months up to 24 Months 2 Years Every Year Until Age 21	**Suggested Dental Checkups** Starting at Age 3 -- Yearly Thereafter **Suggested Vision Checkups** Starting at Age 5 -- Yearly Thereafter **Suggested Hearing Checkups** Ask your child's PCP to determine if hearing tests are needed. **Blood Lead Testing** At ages 12 and 24 months and as directed by your child's PCP.

Recommended Childhood and Adolescent Immunization Schedule											
Age **Immunization**	**Birth**	**1 Mo**	**2 Mos**	**4 Mos**	**6 Mos**	**12 Mos**	**15 Mos**	**18 Mos**	**24 Mos**	**4-6 Yrs**	**11-12 Yrs**
Hepatitis B	HepB	HepB		HepB							
Diphtheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP			DTaP	Tdap
***Haemophilus Influenzae* type b**			Hib	Hib	Hib	Hib					
Inactivated Polio			IPV	IPV		IPV				IPV	
Measles, Mumps, Rubella						MMR				MMR	
Varicella						Varicella					
Pneumococcal			PCV	PCV	PCV	PCV					
Influenza					Influenza (Yearly)						
Meningococcal											MCV4
Hepatitis A						Hep A Series					
Rotavirus			RV	RV	RV						

These screenings should begin as early as possible in a child's life, or as soon as the child is enrolled in EPSDT Medical Assistance Program.

Screening services must include all of the following:

- **Comprehensive health and developmental history** (including assessment of both physical and mental health development);

- **Appropriate immunizations** (according to the schedule under Screening Services above); and

- **Laboratory tests** as age appropriate.

  Note:

  Lead Toxicity Screening-Requirements

  As part of the definition of EPSDT, The Centers for Medicare and Medicaid Services (CMS) requires coverage for children to include screening lead tests appropriate for age and risk factors. All children enrolled in the Medical Assistance Program should be screened for lead at 12 and 24 months of age, since this is the age when children are most at risk. Children over the age of 24 months, up to 72 months of age, for whom no record of a previous screening lead test exists, should also be screened for lead. In addition, coverage must be available for any follow-up services within the scope of the Medical Assistance Plan, including diagnostic or treatment services determined to be medically necessary. Such services would include both case management by the primary care provider (PCP) and a one-time investigation to determine the source of lead for children diagnosed with elevated lead levels. The scope of the investigation is limited to a health professional's time and activities during an on-site investigation of a child's home (or primary residence). Medical Assistance funds are not available for testing of environmental substances such as water, paint or soil. Please contact your local Department of Health for any child that is identified to have an elevated lead level.

- **Health Education-**Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental screening, gives you the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development. Information about the benefits of a healthy lifestyle as well as accident and disease prevention is also essential.

- **Vision Screen-**Administer an age-appropriate vision assessment. The screening provider may refer the child for a thorough vision exam beginning at age 5, with annual exams thereafter up to age 21. Medically necessary vision services including examination and treatment are covered based upon individual needs of the child.

- **Hearing Screen-**At a minimum, include examination, evaluation, diagnosis and treatment for defects in hearing. Medically necessary hearing services are covered based upon individual needs of the child.

- **Dental-**At a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. A dental screening is suggested for every child in accordance with the periodicity schedule defined by South Dakota Medical Assistance EPSDT, starting at age 3 and yearly thereafter. Necessary dental services are covered based upon individual needs.

- **Diagnosis and Treatment-**Screening and diagnostic services to determine physical or mental status and provide health care treatment and other measures to correct or ameliorate defects or chronic conditions discovered are covered under the EPSDT service package.

COVERED SERVICES—LIMITS

EPSDT services are limited to the following:

- Screening services conducted under provisions of Administrative Rule of South Dakota (ARSD) 67:16:11:04, and 67:16:11:04.01;
- Vision services covered under the provisions of ARSD 67:16:08:04;
- Hearing services including examination, evaluation, diagnosis, and treatment for defects in hearing, and the provision of hearing aids;
- Orthopedic shoes when prescribed by a physician;
- Liver transplants under the provisions of ARSD 67:16:11:03.02;
- Psychological services limited to those procedures listed in ARSD 67:16:11:06.04;
- Psychological services when the requirements of ARSD 67:16:11:03.03 have been met;
- Treatment for chemical dependency when the requirements of ARSD 67:16:11:03.04, or §67:16:11:03.17 have been met;
- Orthodontic services when the requirements of ARSD 67:16:11:03.06, §67:16:11:03.07, §67:16:11:03.08 and §67:16:11:03.09 have been met;
- Prescribed legend drugs;
- Medical equipment when the requirements of ARSD 67:16:11:03.18 have been met;
- Other services based on medical necessity, providing necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services;
- Home-based therapy services when the requirements of ARSD 67:16:11:03.10 and §67:16:11:03.16 are met;
- Home health services when requirements of ARSD 67:16:11:03.09 have been met;
- Private duty nursing services when the requirements of ARSD 67:16:11:03.20 have been met; and

- Extended home health aide services when the requirements of ARSD 67:16:11:03.21 have been met.

  NOTE: Cost not to exceed long-term institutional care-When the actual or projected cost of all services provided in the home over a period of three months exceeds 135 percent of the cost of care if the individual was institutionalized in a long-term care facility, the department shall issue a notice of intent to discontinue or deny further service. The notice shall be sent to the provider and the individual. If within 60 days after the notice the provider furnishes documentation that the future service costs in the home will decline and be within 135 percent of the cost of long-term care, the department shall reconsider its decision.

RATE OF PAYMENT

Refer to www.state.sd.us/social/medical/provider/.

NON-COVERED SERVICES

Some services are not covered under the EPSDT program. Non-covered services include the following:

- Services which are determined by the state medical consultant or dental contractor to be not necessary, safe, or effective;
- Diagnosis or treatment given in the absence of the recipient;
- Attendance of two providers, with the exception of physicians, on the same case at the same time, unless approved by the department;
- Services provided by an employee of federal, state, or county government. This does not include employees of the public health service or the national health service;
- Services, procedures, or drugs which are considered experimental;
- Cosmetic surgery or services to improve the appearance of an individual when not incidental to prompt repair following an accidental injury, or any cosmetic surgery or service which goes beyond that which is necessary for the improvement of the functioning of a malformed body member;
- Drugs and biologicals which the federal government has determined to be less than effective as listed in ARSD 67:16:14.05(13); and
- Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment such as air conditioners, humidifiers, dehumidifiers, heaters, or furnaces.

COST-SHARE PARTICIPANTS

Cost sharing for EPSDT services provided to individuals 19 years of age and over on the date of service is as follows:

- $3 for each screening;
- $3 for each dental procedure;
- $3 for dentures;
- $2 for each optometric or optical procedure;
- $2 for each lens change;
- $2 for each frame change;
- $2 for other frame parts;
- $2 for repair service;
- $3 for each psychological service, except psychological testing;
- $3 for each orthodontic service;
- Five percent of the allowable payment for chemical dependency treatment;
- $3 for each prescription; and
- Five percent of the allowable payment for medical equipment.

For a listing of cost-sharing participants refer to ARSD 67:16:01.22.

Billing Requirements

A provider submitting a claim for reimbursement under ARSD 67:16:11 must submit the claim at the provider's usual and customary charge.

The laboratory that actually performs the laboratory test must submit the claim for the test.

Claim Requirements

A claim for services covered under this chapter must be submitted according to the following requirements:

- For complete, comprehensive screenings and partial screenings, follow the requirements in ARSD 67:16:11:19.03;
- For vision services, follow the claim requirements of ARSD 67:16:08;

- For hearing tests and exams, orthopedic shoes, liver transplants, and other physician services, follow the claim requirements of ARSD 67:16:02;

- For psychological services, follow the claim requirements of ARSD 67:16:11:19;

- For psychiatric hospital services, follow the claim requirements of ARSD 67:16:03;

- For chemical dependency services, include the applicable procedure codes listed in §67:16:11:06.07 and follow the claim requirements of ARSD 67:16:11:15;

- For prescribed legend drugs, follow the claim requirements of ARSD 67:16:14;

- For medical equipment and hearing aids and supplies, follow the claim requirements of ARSD 67:16:29;

- For home health services, follow the claim requirements of ARSD 67:16:05.09;

- For private duty nursing, include the applicable procedure code contained in §67:16:11:06.15 and follow the claim requirements of ARSD 67:16:11:19.02;

- For extended home health aide services, include the procedure code T1020 and follow the claim requirements of ARSD 67:16:11:19.02; and

- For complete, comprehensive screenings and partial screenings, follow the requirements in ARSD 67:16:11:19.03.

CHAPTER VII

HOME HEALTH AGENCY

INDIVIDUAL ELIGIBILITY

Home health services are available to an individual in the individual's place of residence. The individual must be eligible for medical assistance and the required services must meet the conditions of Administrative Rule of South Dakota (ARSD) 67:16:05.

PROGRAM REQUIREMENTS

Certain requirements must be met before an agency can begin providing services to an individual. The requirements are listed in ARSD 67:16:05:05.02.

NOTE: The home health agency must obtain Medicare certification or recertification, as necessary.

COVERED SERVICES

Home health services must meet medical necessity requirements and are limited to those covered services listed in ARSD 67:16:05:05.

NOTE; A supervisory visit by a registered nurse must be conducted at least once every two weeks to determine if the recipient's health care needs and goals contained in the plan of care are met. The presence of the home health aide is required during the supervisory visits.

SERVICE RESTRICTIONS

Home health service restrictions must meet the criteria listed in ARSD 67:16:05:05.01.

NON-COVERED SERVICES

Non-covered services may be found in ARSD 67:16:05:06.

PROFESSIONAL SERVICES

Payment for professional services is limited to the home health agency's usual and customary charge or the table found in ARSD 67:16:05:07.

BILLING REQUIREMENTS

A claim submitted for services provided under the home health agency must be submitted at the providers usual and customary charge and must contain the procedure codes listed in ARSD 67:16:05:07.

NOTE: Medical equipment claims must be submitted by a participating durable medical equipment provider.

SERVICES PROVIDED OUT OF STATE

Services provided outside of South Dakota will be covered services if all the following are met:

1. Services provided are covered under ARSD 67:16:05;
2. The home health agency has signed a provider agreement with the department; and
3. The home health agency is a participating provider in the Medical Assistance Program in the state in which the services are provided.

CHAPTER VIII

OPTOMETRIC SERVICES

NOTE: This provider range is exempt from Managed Care

COVERED SERVICES

Optometric services are allowed for both children and adults. There is no age restriction for eye examinations and/or refractions. Optometric services limitations may be found in Administrative Rule of South Dakota (ARSD) 67:16:08:04.

A claim for optical supplies may not be submitted until after the item is delivered to the recipient.

NOTE: A recipient is eligible to receive new lenses and/or frames after a minimum of 15 months have passed since the last glasses were received, only if the medically necessary requirements are met.

NON-COVERED SERVICES

The list of services **not covered** under Medical Assistance Program are located at ARSD 67:16:08:05. If non-covered services are provided, the reimbursement must be obtained from the recipient.

PROCEDURE CODES AND PRICES

A claim must be submitted at the providers usual and customary charge and is limited to the procedures found at ARSD 67:16:08:11.

NOTE: After Medical Assistance Program has made payment on any procedure(s) the provider may not bill the recipient for any part of the charge. Therefore, if a recipient chooses a more expensive frame or lenses, the provider may either accept Medical Assistance Program's payment in full, or bill the recipient for the entire amount.

OTHER OPTICAL CARE

A claim must be submitted at the provider's usual and customary charge and is limited to procedures listed in ARSD 67:16:08:11. Payment is limited to the lesser of the provider's usual and customary charge or the amount specified in ARSD 67:16:08:11.

CHAPTER IX

PODIATRY SERVICES

NOTE: Podiatry providers are exempt from Managed Care.

COVERED SERVICES

Covered podiatry services are located in Administrative Rule of South Dakota (ARSD) 67:16:07:03.

NON-COVERED SERVICES

In addition to other services not specifically listed in the covered services section of Administrative Rule, podiatry services not covered under the Medical Assistance Program are located at ARSD 67:16:07:04.

CHAPTER X

MEDICAL ASSISTANCE PRIMARY CARE PROVIDER PROGRAM

South Dakota's Medical Assistance Primary Care Provider Program is a managed health care system that requires approximately three-fourths of our Medical Assistance recipients to enroll. Certain Medical Assistance recipients must choose one primary care provider (PCP) to be their health care case manager. This program creates a "partnership" between the PCP and the Medical Assistance Program recipient where the PCP is responsible for providing or directing all managed care designated services.

The Managed Care Program is designed to improve access, availability and continuation of care while reducing inappropriate utilization, over utilization, and duplication of Medical Assistance Program covered services while operating a cost-effective program.

WHO MAY PARTICIPATE AS A PRIMARY CARE PROVIDER (PCP)

- Family and General Practitioners
- Pediatricians
- Internal Medicine
- OB/GYN
- Clinics certified as a Rural Health Clinic (RHC)
- Clinics certified as a Federally Qualified Health Center (FQHC)
- Clinics designated as an Indian Health Services Clinic
- Other licensed physicians or osteopaths who agree to provide primary health care and case management services according to program requirements.

HOW THE PROGRAM WORKS

PCPs receive lists at the beginning of each month showing Medical Assistance Program recipients enrolled under their caseload. Each PCP provides comprehensive primary health care services for all of the PCP's enrollees. As their case manager, the PCP will refer (authorize) recipients for specialty care only when medically necessary. Managed care covered services not authorized by the PCP are not payable by the Medical Assistance Program.

Participating PCPs receive a monthly case management fee for each recipient who is enrolled with the physician, regardless of whether the physician has provided services to the recipient during the month. Exceptions to this rule are Rural Health Clinics, Federally Qualified Health Centers and Indian Health Services Clinics. They are reimbursed differently than the fee for service physicians.

Medical providers interested in enrolling as a PCP must complete and submit an *Addendum to the Provider Agreement*. Providers may obtain an agreement by contacting this office's Provider Enrollment personnel at (605) 773-3495 or by accessing our web site at **www.state.sd.us/social/medical.**

MANAGED CARE SERVICES

The following Medical Assistance Program covered services must be provided by the PCP or be prior referred/authorized by the PCP.

- Physician/Clinic Services;
- Inpatient/Outpatient Hospital Services;
- Home Health Services;
- Rehabilitation Hospital Services;
- Psychological Treatment;
- Durable Medical Equipment Services;
- School District Services;
- Ambulatory Surgical Center Services;
- Healthy Kids Klub Visits (screening);
- Mental Health Services;
- NP's, PA's, and Nurse Midwives;
- Residential Treatment;
- Ophthalmology (medical complications, non-routine);
- Therapy (Physical/Speech);
- Community Mental Health Centers;
- Pregnancy-related Services; and
- Lab/X-Ray Services (at another facility);

NON–MANAGED CARE SERVICES

The following Medical Assistance Program covered services are exempt from the Managed Care Program. Medical Assistance Program eligible recipients do NOT need referrals from their PCPs to access the following Medical Assistance Program covered services.

- "True" emergency services (and related pharmacy);
- Family planning services (and related pharmacy);
- Dental/Orthodontic Services (and related pharmacy);
- Chemical dependency treatment;
- Prescription Drug Services;
- Podiatry services;
- Optometric/optical services (routine eye care);
- Chiropractic services;
- Immunizations;
- Mental health services for SED/SPMI recipients;
- Ambulance/transportation;
- Anesthesiology;
- Independent radiology/pathology; and
- Independent lab/x-ray services *(when sending samples or specimens to any outside facility for analysis only).
- Services referred by Indian Health Services to medical providers who have a current contract with Indian Health Services.

VERIFYING MANAGED CARE INFORMATION

The State provides all PCPs with a monthly caseload report. This report shows all recipients enrolled with the particular PCP on the first day of the report month. Providers may also utilize MEVS to verify PCP enrollment (refer to *MEVS ELIGIBILITY INFORMATION* in chapter 1 of this manual).

MEDICAL ASSISTANCE PCP REFERRAL/AUTHORIZATION

Referrals issued by a recipient's primary care provider (PCP) or covering provider to other medical providers is a key component of the managed healthcare program. Most of a recipient's care falls within the realm of 'managed care services'. These are services that must be provided or referred to other medical providers by the PCP. Recipient's can self-refer for services that are exempt from these provisions such as: "true" emergency care, dental, pharmacy and family planning.

Referrals:

An authorization or 'direction of care' from a recipient's PCP to another medical provider. Referrals do not supersede other program requirements such as: medical necessity, eligibility, program prior authorization requirements and coverage limitations. Travel distances and the availability of in-state services should be considered prior to making out-of-state referrals.

Required Referral information:

- Recipient name;
- Referred to provider's name;
- Services or condition;
- Time-span (not to exceed one year); or
- Number of visits authorized;
- PCP name;
- PCP provider number; and
- Date and authorized signature.

Optional Referral information:

In addition to required information, the PCP may include other information such as:

- Specific directions;
- Progress notes; and
- What services should be referred back to the PCP.

Referral Verifications:

The most common way to verify a referral is the use of state provided referral cards. These cards contain the "required referral information". PCPs may utilize other appropriate verifications such as:

- Documented telephone referrals
- Referral letters
- Customized referral forms
- Other insurance referral forms
- Hospital admittance letters
- Certificates of medical necessity (CMN)
- Other (must contain "required referral information")

Referral Card:

MEDICAID MANAGED CARE REFERRAL CARD

I'm referring (authorizing) _____ to
(Recipient Name)

_____ for medically (Specialty Provider) necessary Medicaid covered services.
Authorization limits services three (3) months or less.

_____
Primary Care Provider Name/Phone Number

_____
Primary Care Provider Medicaid ID#

_____
Primary Care Provider mailing Address

_____
Attending Physician Signature/Authorization Date

_____
Signature of Specialty Provider Date

_____
Signature of Further Specialty Provider Date

When the above services have been completed, the final specialty provider should send a copy of this card back to the Primary Care Provider

In-House Referral:

In-House referrals are considered implied or otherwise automatic referrals. Formal referral verification is not required for in-house referrals. In-house referrals occur when a beneficiary is seen by a PCP's covering provider for primary care services within the same clinic (i.e., CNP, PA or other covering physician).

Outside referral:

These referrals require verification. They are usually for services the PCP does not normally provide such as:

- Specialty care;
- Hospital care;
- Durable medical equipment;
- Home health care; and
- Diabetes education.

Referral verifications are also required for primary care services provided outside of the PCP's clinic. This usually occurs when a patient is visiting out of town and needs non-emergency medical care (usually made for one or two visits) or to facilitate a change in PCPs (usually made for a month or less).

Further Referrals:
A referred provider may refer the recipient for further medical services. Further referrals can only be extended within the original time frame initially authorized by the recipient's PCP (not to exceed one year) and for the original services or condition authorized.

Retroactive Referral:

A retroactive or backdated referral is considered inappropriate. Providing verification to follow-up on a verbal authorization or direction from the PCP or covering provider made prior to the service is allowed.

Verifying Referrals:

When verifying or back-tracking referrals previously received from sources other than the recipient's PCP, the last referring provider should be contacted to confirm the authorization information. i.e., hospital consulting services, further referred specialty services, DME, Home Health, etc.

EMERGENCY CARE

"True" emergency care does not require primary care provider (PCP) referrals. Managed care beneficiaries may access "true" emergency care from clinics, physicians, nurse practitioners, physician assistants, after-hours clinics and hospital emergency rooms.

The South Dakota Medical Assistance Program utilizes the prudent layperson definition for the determination of an "emergency medical condition". The determination of whether the prudent layperson standard has been met must be focused on the presenting symptoms (and not on the final diagnosis), and must take into account that the decision to seek emergency care was made by a prudent layperson (rather than a medical professional).

Prudent Layperson Emergency Definition

An "emergency medical condition": is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Qualified medical personnel must determine whether the individual requires emergency care. An emergency condition determination must be documented and the information forwarded to the facility's billing and coding personnel for proper billing of the service. Routine care for minor illness and injury is usually considered **not** to be a "true emergency" service.

If the examining provider determines, after study, that an emergency medical condition does not exist, the Prudent Layperson standard must be followed. The determining factor for an emergency condition should be whether the beneficiary had acute symptoms of sufficient severity to have warranted emergency attention at the time of presentation.

REIMBURSEMENT FOR MANAGED CARE RECIPIENTS

Medical services for enrolled managed care recipients are reimbursed on a fee-for-service (FFS) basis. Claims for covered medical services provided by the PCP do not require additional managed care information on the claim. Covered Managed Care Services provided by providers referred by the PCP must have the PCP's provider number included on the claim according to Chapter XV Block 17a. Exempt emergency care, urgent care, IHS referred contract care and dental related care must be billed according to Chapter XV Block 10d. Exempt mental health services for recipients diagnosed as SED or SPMI must be billed with the HE modifier according to Chapter II under *modifier codes*. Exempt family planning services should be billed with an "F" in Block 24H according to Chapter XV Block 24.

INFORMATION ON THE WEB

Information on the PCP Program is available by following the *Managed Care* links at **www.state.sd.us/social/medical.**

CHAPTER XI

MENTAL HEALTH SERVICES BY INDEPENDENT PRACITIONERS

COVERED SERVICES AND BASIS FOR PAYMENT

REQUIREMENTS

Mental health services under this chapter are limited to services provided by a mental health provider who meets the following certification and licensing requirements.. A mental health provider may be any one of the following individuals who has signed a provider agreement with the department to provide mental health services:

1. A psychologist;
2. A certified social worker;
3. Private Independent Practice – PIP;
4. Licensed Professional Counselor – Mental Health - LPC - MH; or
5. Certified Nurse Specialist – CNS.

A mental health provider must have a Medical Assistance Program provider identification number and may not provide services under another provider's or a employers Medical Assistance Program provider identification number.

An individual who does not meet the certification or licensure requirements of the applicable profession may not enroll as a mental health provider or participate in the delivery of mental health services.

LIMITATIONS

Mental health services are limited to services established in this chapter which meet all of the following requirements:

1. The mental health provider has prepared a diagnostic assessment;
2. The diagnostic assessment contains a primary diagnosis of one of the mental disorders listed under Covered Mental Health Services, located in this manual;
3. The mental health provider has prepared an individual treatment plan;
4. The mental health provider provides treatment directly to the recipient;
5. The treatment is documented in the recipient's clinical record;
6. The treatment is medically necessary.

Failure to meet all of the above requirements will be cause for the department to determine the mental health services to the non-covered services.

DIAGNOSTIC ASSESSMENT REQUIREMENTS

Preparation of the recipient's diagnostic assessment must begin during the mental health provider's first face-to-face interview with the recipient. The diagnostic assessment does not need to be completed in one clinical psychiatric diagnostic or evaluation interview, but must be completed before the fourth face-to-face interview with the recipient. The fourth or any subsequent face-to-face interview designed to assist in the formulation of a diagnostic assessment is considered a non-covered service. Psychiatric therapeutic procedures or psychiatric somatotherapy provided before the diagnostic assessment is completed are considered non-covered services.

A diagnostic assessment must include **all** of the following components:

1. A face-to-face interview with the recipient;
2. An examination of the recipient's mental status including a description of anomalies in the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward the symptoms;
3. A review of the records which pertain to the recipient's medical and social background and history, if available;
4. Contact with the recipient's relatives and significant others to the extent necessary to complete an accurate psychological evaluation for the purpose of writing the assessment report and developing the treatment plan; and
5. Formulation of a diagnosis which is consistent with the findings of the evaluation of the recipient's condition.

The mental health provider must complete, sign and date the treatment plan before the fourth face-to-face session with the recipient. The signature is a certification by the mental health provider that the treatment plan is accurate. The certification date is the effective date of the treatment plan.

TREATMENT PLAN REQUIREMENTS

The mental health provider must develop a treatment plan for each recipient who is receiving medically necessary covered mental health services based on a primary diagnosis of a mental disorder. The plan must be relevant to the diagnosis, be developmentally appropriate for mental health services, and relate to each covered mental health service to be delivered.

The treatment plan must meet **all** of the following requirements:

1. Be developed jointly by the recipient, or legal guardian, and the mental health provider who will be providing the covered mental health services;
2. Include a list of other professionals known to be involved in the case;
3. Contain written objectives which specifically address the recipient's individual treatment goals;
4. Be based on the findings of the diagnostic assessment and contain the recipient's mental disorder diagnosis code;
5. List specific services, therapies, and activities prescribed for meeting the treatment goals;
6. Include the specific treatment goal for improving the recipient's condition to a point of no longer needing mental health services; and
7. Include a specific schedule of treatment services including the prescribed frequency and duration of each mental health service to be provided to meet the treatment plan goal.

The mental health provider must complete, sign and date the treatment plan before the fourth face-to-face session with the recipient. The signature is a certification by the mental health provider that the treatment plan is accurate. The certification date is the effective date of the treatment plan.

Mental health services provided after the third face-to-face session with the recipient without a supporting treatment plan meeting the requirements of this section are considered non-covered services.

TREATMENT PLAN REVIEWS

As long as mental health services continue, the mental health provider must review the recipient's treatment plan at least semi-annually with the first review completed no later than six months from the effective date of the initial treatment plan. Each semi-annual review must contain a written review of the progress made toward the established treatment goals, significant changes to the treatment goals, and a justification for continued mental health services. When there is a significant change in the recipient's treatment goals, the mental health provider must review the treatment plan and record the changes in the treatment plan.

The mental health provider who conducted the review and prepared the written documentation must sign and date the documentation.

Covered mental health services provided without the required semi-annual treatment plan review or without significant changes added into the treatment plan, as required in this section, are considered non-covered services.

CLINICAL RECORD REQUIREMENTS

The mental health provider must maintain the recipient's clinical record. In addition to the record requirements contained in ARSD chapter 67:16:34, the recipient's clinical record must contain all of the following information, including the related supporting clinical data:

1. Concise data on client history, including present illness and complaints, past history (psychological, social, and medical), previous hospitalization and treatment, and a drug-use profile;
2. A diagnostic assessment;
3. A treatment plan;
4. A chronological record of known phychotrophic medications prescribed and dispensed;
5. Documentation of treatment plan reviews;
6. The specific services provided together with the date and amount of time of delivery of each service provided;
7. The handwritten signature or initials and credential of the mental health provider providing service;
8. The location of the setting in which the service was provided;
9. The relationship of the service to the treatment plan objectives and goals;
10. Progress or treatment notes, entered chronologically at each encounter of service, documenting and summarizing progress the recipient is making during a given period of time toward attaining the treatment objectives and goals; an assessment of the recipient's current symptoms; a report of procedures administered during the session; and a plan for the next treatment session; and

11. When the treatment is complete or discontinued, a discharge summary which relates to the treatment received and progress made in achieving the treatment goals. A discharge summary is not required when the recipient prematurely discontinues the treatment.

All entries within the required clinical record must be current, consistently organized, legible, signed or initialed, and dated by the mental health provider.

BILLING REQUIREMENTS

The following restrictions apply:

1. A provider may not submit a claim under another provider's identification number. A claim must contain the Medical Assistance Program provider identification number of the individual delivering the service;
2. A provider may not submit a claim for a diagnostic assessment which exceeds four hours unless there has been a break of at least 12 months in the delivery of mental health services to the recipient;
3. A provider may not submit a claim for a diagnostic assessment until the assessment is completed and recorded in the recipient's clinical record;
4. A provider may not submit a claim for mental health services provided before the diagnostic assessment is completed;
5. A provider may not submit a claim for mental health services provided after the fourth face-to-face session with recipient and before the effective date of the treatment plan;
6. A provider may not submit a claim for individual psychotherapy if more than one person is in a psychotherapy session even though only one person may be eligible for the Medical Assistance Program. The service must be billed as family or group psychotherapy, whichever is appropriate;
7. A provider may not submit a claim if a recipient is involved in a psychotherapy session not as an individual mental health client but only as part of a family or group session for treatment of another family member who is a mental health client;
8. Except for a psychiatric diagnostic interview examination and a diagnostic assessment, a provider may not submit a claim for a mental health service if the recipient does not have a primary diagnosis of a mental disorder, and a provider may submit a claim for each eligible recipient in a family or group psychotherapy session who is actively receiving psychotherapy. In these cases each family or group member for whom services are billed to must have a complete clinical record.

The provider must submit claims at the provider's usual and customary charge and the claim may contain only those procedure codes listed below.

COVERED SERVICES

Mental disorder diagnosis codes are limited to the diagnosis range of 290.0 to 301.9, inclusive and 306.0 to 315.9 inclusive, contained in the ICD-9-CM adopted in ARSD 67:16:01:26.

The focus of mental health services must be for the treatment of the primary diagnosis which may not be mental retardation. Mental retardation is considered a developmental disability and is not considered a mental disorder. Primary diagnosis codes for mental retardation are not included in covered mental health services under this chapter.

Payments for mental health services is the lesser of the provider's usual and customary charge or the established fee. If there is no established fee, payment is 40% of the provider's usual and customary charge. Mental health services are limited to the following:

CLINICAL PSYCHIATRIC DIAGNOSTIC OR EVALUATION INTERVIEW PROCEDURES

CODES	DESCRIPTION
90801	Psychiatric diagnostic interview examination.
96100	Psychological testing, with interpretation and report, per hour, limited to a licensed psychologist.

PSYCHIATRIC THERAPEUTIC PROCEDURES

Psychiatric therapeutic procedures are limited to only those recipients who have been determined to have a primary diagnosis of a mental disorder according to the findings of the diagnostic assessment.

Time units are for face-to-face sessions times with the recipient and do not include time used for traveling, reporting, charting, or other administrative functions.

If a recipient receives a combination of individual, family, or group psychotherapy, the maximum allowable coverage for all services may not exceed the payment allowed for 40 hours of individual therapy in a 12 month period.

CODE	DESCRIPTION
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.
90847	Family psychotherapy, (conjoint psychotherapy) (with patient present).
90849	Multiple-family group psychotherapy.
90853	Group medical psychotherapy, (other than a multiple-family group).

NON-COVERED SERVICES

The department does not cover and the provider may not submit a claim for any of the following non-covered services:

1. Mental health services not specifically listed in ARSD 67:16:41;
2. Mental health treatment provided without the recipient physically present in a face-to-face session with the mental health provider;

3. Treatment for a diagnosis not contained in the Covered Mental Health Services section of this manual;
4. Mental health services provided before the diagnostic assessment is completed;
5. Mental health services provided after the fourth face-to-face session with the recipient if a treatment plan has not been completed;
6. Mental health services provided if a required review has not been completed;
7. Court appearance, staffing sessions, or treatment team appearances;
8. Mental health services provided to a recipient incarcerated in a correctional facility;
9. Mental health services provided to a recipient in an IMD or ICF/MR institution;
10. Mental health services provided which do not demonstrate a continuum of progress toward the specific goals stated in the treatment plan. Progress must be made within a reasonable time as determined by the peer review entity;
11. Mental health services provided which are not listed in the treatment plan or documented in the recipient's clinical record even though the service is allowable under ARSD 67:16:41;
12. Mental health services provided to a recipient who is incapable of cognitive functioning due to age or mental incapacity or is unable to receive any benefit from the service;
13. Mental health services performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint;
14. Time spent preparing reports, treatment plans, or clinical records;
15. A service designed to assist a recipient regulate a bodily function controlled by the autonomic nervous system by using an instrument to monitor the function and signal the changes in the function;
16. Alcohol or drug rehabilitation therapy;
17. Missed or cancelled appointments;
18. Interpretation or explanation of results of psychiatric, or other medical examinations and procedures, or other accumulated data to family or another responsible person of advising them how to assist the recipient;
19. Medical hypnotherapy;
20. Field trips and other off-site activities;
21. Consultations or meetings between an employer and employee;
22. Review of work product by the treating mental health provider;
23. Telephone consultations with or on behalf of the recipient;
24. Educational, vocational, socialization, or recreational services or components of services of which the basic nature is to provide these services, which includes parental counseling or bonding, sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, and psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness, activity group therapy, family counseling, recreational therapy, structural integration, occupational therapy, consciousness training, vocational counseling, marital counseling, peer relations therapy, day care, play observation, sleep observation, sex therapy, milieu therapy, training disability service, primal scream, bioenergetics therapy, guided imager, Z-therapy, obesity control therapy, dance therapy, music therapy, educational activities, religious counseling, tape therapy, and recorded psychotherapy;
25. Mental health services delivered in excess of the prescribed frequency as outlined in the treatment plan; and
26. Mental health services provided by any Medical Assistance Program provider other than the recipient's primary care provider under the provisions of 67:16:39:08, unless the recipient has been formally diagnosed as severely emotionally disturbed or severely persistently mentally ill.

PRIOR AUTHORIZATION

A mental health provider must have prior authorization from the department before providing any covered mental health services which will exceed the established limits. Authorization is based on documentation submitted to the department by the mental health provider. The documentation must include the provider's written treatment plan, the diagnosis, and the planned treatment.

Failure to obtain approval from the department before providing the service is cause for the department to determine that the service provided is a non-covered service.

The department may verbally authorize services; however, the department must verify a verbal authorization in writing before the services are paid.

Services which exceed the established limits are subject to peer reviews. A peer review entity appointed by the department shall review claims to determine and ensure the appropriate quality, quantity and medical necessity of mental health services provided.

HAND WRITTEN ORIGINALS REQUIRED

Except for the claim form, all signatures, initials, certifications, and dates required under this chapter must be handwritten originals and will be considered written instruments and subject to the provisions of SDCL 22-39-36.

CHAPTER XII

SCHOOL DISTRICT

COVERED SERVICES AND PROCEDURE CODES

PROVIDER REQUIREMENTS

09SCHOOL DISTRICT: The school district is an educational unit which meets the requirements established in South Dakota Codified Law (SDCL) 13-5-1; an agency which operates a special education program for children with disabilities, birth through 21 years of age and meets the requirements of article 24:05; or a cooperative special education unit created by two or more school districts under SDCL 13-37-14.2.

A school district may be a Medical Assistance Program provider if all of the following conditions are met:

NOTE: Appendix is located on at the end of this chapter.

1. The school district provides any of the services covered as outlined in Appendix A;
2. The covered services are provided by an employee of the school district or by an individual who is under contract with the school district and who meets the applicable licensing or certification requirements; and
3. The school district has a signed provider agreement with the Department of Social Services.

PROFESSIONAL LICENSURSE OR CERTIFICATION REQUIREMENTS FOR COVERED SERVICES

Individual professionals employed by or under contract with a School District who provide one of the following medically necessary covered services must meet the appropriate licensure or certification requirement:

Psychology:

A licensed psychologist under SDCL 36-27A, a school psychologist or a school psychological examiner certified under article 24:02.

Physical Therapy:

A licensed physical therapist or a certified graduate physical therapy assistant under SDCL 36-10.

Occupational Therapy:

A licensed occupational therapist or a licensed occupational therapy assistant under SDCL 36-31 and article 20:64.

Speech Therapy:

A speech pathologist who is Medicare-certified or has a certificate of clinical competence from the American Speech and Hearing Association; has completed the equivalent educational requirements and work experience necessary for a certificate of clinical competence from the American Speech and Hearing Association; has completed the academic program and is acquiring supervised work experience to qualify for the certification; or as defined in §67:16:37:01 of South Dakota Administrative Rule.

Audiology:

An audiologist who is Medicare-certified and has a certificate of clinical competence from the American Speech and Hearing Association; has completed the equivalent educational requirements and work experience necessary for the certification; or has completed the academic program and is acquiring supervised work experience to qualify for the certification.

Nursing Services:

Nursing services listed in §67:16:37:11 must be provided by a professional nurse who is licensed under SDCL 36-9.

LIMITS—COVERED SERVICES

All services listed in Appendix A which are provided under this program must meet **all** of the following conditions:

1. Services must be medically necessary and documented in recipient's record;
2. Services must be outlined in the recipients care plan;
3. Services must be within the professional's scope of practice;
4. There must be direct, face to face contact-care with the recipient;
5. Services must be provided only to recipients under 21 years of age; and
6. Services must be provided by the school district in which the recipient is enrolled.

PLAN OF CARE – REQUIREMENTS

Each individual receiving services under this program must have a plan of care. A plan of care is a written plan for a particular individual which outlines medically necessary health services and the duration of those services. Each plan must meet all of the following requirements:

1. Plan of care must be prepared by the professional involved in the child's care;
2. An individual education plan (IEP) or an individual family service plan (IFSP) may be used as the plan of care;
3. Plan of care is effective no more than one school year;
4. Plan of care must be amended as warranted by change in the individual's medical condition; and
5. Except for initial evaluations and testing, there must be a physician's written orders for medical services required under the plan of care.

BILLING REQUIREMENTS

Claims submitted by a School District must be at the provider's usual and customary charge.

The school must submit the claim when the service is listed in the child's individual education plan and is covered in Appendix A. This rule does not apply to services provided to an individual who has been admitted to a hospital as an inpatient, or who is residing in a residential treatment center, an adjustment training center, a community rehabilitation facility, a nursing facility, or an intermediate care facility for the mentally challenged. Claims for these services must be submitted according to the applicable chapters of ARSD 67:16.

APPENDIX A

SCHOOL DISTRICT PROCEDURES

Payment is limited to the **lesser** of the federal share of the provider's usual and customary charge or the federal share of the rate negotiated between the Department of Education and the School District.

FOR ALL LISTED SERVICES **1 UNIT EQUALS 15 MINUTES.**

PROCEDURE CODE	**DESCRIPTION**
90899	**Psychological Services**

1. Psychological testing, with written report;
2. Diagnostic assessment: Therapeutic contacts with the recipient, family, and significant others to the extent necessary to complete an accurate psychological evaluation and diagnosis, limited to two hours annually per recipient unless there is at least a break of 12 months in providing psychological services;
3. Individual medical psychotherapy: one on one and face-to-face contact between the recipient and the provider, including psychoanalysis or insight-oriented, behavior modifying, or supportive psychotherapy, not to exceed 60 hours in any 12 month period;
4. Family medical psychotherapy (conjoint psychotherapy): face-to-face contact between the recipient and the provider and one or more family members, including psychoanalysis or insight-oriented, behavior modifying, or supportive psychotherapy, not to exceed 60 hours in any 12 month period;
5. Multiple-family group medical psychotherapy: face-to-face contact between the recipient, the provider, and more than one family, including psychoanalysis or insight-oriented, behavior modifying, or supportive psychotherapy, not to exceed 60 hours in any 12 month period;
6. Group medical psychotherapy (other than of a multi-family group): face-to-face contact between the recipient, the provider, and one or more group members including psychoanalysis or insight-oriented, behavior-modifying, or supportive psychotherapy, not to exceed 60 hours in any 12 month period.

97799	**Physical Therapy Services**
97003	**Occupational Therapy Services**
92507	**Speech Therapy Services**
92700	**Audiology Services**
T1001	**Nursing Services**

1. Nursing evaluation or assessment, which includes observation of recipients with chronic medical illnesses in order to assure that medical needs are being appropriately identified addressed, and monitored; maximum of four (4) units per evaluation/assessment per day;
2. Nursing treatment, which includes administration of medication: management and care of specialized feeding program, management and care of specialized medical equipment such as colostomy bags, nasalgastric tubes, tracheostomy tubes; maximum of four (4) units per nursing treatment per day;
3. Extended nursing care for a technology-dependent child who relies on life-sustaining medical technology to compensate for the loss of a vital body function and requires ongoing complex hospital-level nursing care to avert death or further disability; LIMITED to services provided in the school during normal school hours.

Routine nursing services which are provided to all students by a school nurse such as treatment of minor abrasions, cuts and contusions, recording of temperature or blood pressure, and evaluation or assessment of acute illness are **NOT** covered services.

CHAPTER XIII

TRANSPORTATION

COVERED SERVICES AND REIMBURSEMENT

COVERED AMBULANCE SERVICES

Air or ground ambulance services are limited to transporting a recipient locally or to the nearest medical provider that is equipped or trained to provide the necessary service. The following services are eligible for payment when provided by a participating ambulance provider:

1. Ground ambulance services are to or from a medical provider, or between medical facilities when other means of transportation would endanger the life or health of the recipient.
2. Air ambulance services must meet the following criteria:
    a. The transportation is medically necessary because of time, distance, emergency, or other factors or when transportation by any other means is contraindicated;
    b. The transportation must be the result of a physician's written orders requiring the specific level of air transportation for medical purposes;
    c. The provider must be licensed according to ARSD 44:04:05 or licensed as an air ambulance in the state where the provider is located;
3. Services of additional attendants when determined necessary by the provider.

GROUND AMBULANCE

A claim for ground ambulance transportation service must be submitted at the provider's usual and customary charge. A provider may bill for services only if a recipient was actually transported. A provider may not bill for any portion of ambulance service during which the recipient was not physically present in the ambulance.

Return trips or other non-emergency trips by ground ambulance must be justified by a physician's order. Documentation of the order must exist in the provider's file but need not be submitted with the claim for payment.

A claim for ground ambulance service with BLS may contain only procedure codes established in Administrative Rule of South Dakota (ARSD) 67:16:25:03. A claim for ground ambulance service with advanced life support may contain only procedure codes established in ARSD 67:16:25:03.01. If an ambulance is licensed to provide advanced life support (ALS) services but the services provided on behalf on an eligible recipient are limited to basic life support services, the provider's claim for services is limited to BLS procedure codes established in ARSD 67:16:25:03.

Charges for transporting the recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.

AIR AMBULANCE

A claim for air ambulance must be submitted at the provider's usual and customary charge. A provider may bill for services only if a recipient was actually transported. A provider may not bill for any portion of ambulance services during which the recipient was not physically present in the air ambulance.

A claim for medical air transport must contain the applicable procedure codes established in ARSD 67:16:25:02. A claim for basic life support air ambulance may contain only the applicable procedure codes established in ARSD 67:16:25:03. A claim for advanced life support air ambulance may contain only applicable procedure codes established in ARSD 67:16:25:03.04.

If an air ambulance is licensed to provide advanced life support services, but the services provided on behalf of an eligible recipient are limited to basic life support services or medical air transport, the provider's claim for services is limited to the procedure codes established in ARSD 67:16:25:03.02 or 67:16:25:03.03.

Charges for transporting the recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.

A copy of the physician's written order specifying the medical necessity and the level of air transportation medically required must be maintained in the provider's records and made available on request.

MEDICAL AIR TRANSPORT:
Those medical services provided by an air ambulance which is equipped according to the Department of Health ARSD 44:05:05.12(1).

BASIC LIFE SUPPORT AIR AMBULANCE:

Those medical services provided by an air ambulance that is equipped according to Department of Health ARSD 44:05:05.12(2).

ADVANCED LIFE SUPPORT AIR AMBULANCE:

Those medical services provided by an air ambulance which is equipped according to Department of Health ARSD 44:05:05.12(03).

If an additional Medical Assistance Program recipient is transported at the same time, the claim for the additional recipient is limited to procedure code found in ARSD 67:16:25:03.02

COVERED SERVICES-NON EMERGENCY

A participating wheelchair transportation provider is eligible to receive payment for non-emergency transportation services. Recipients being transported must be confined to a wheelchair or must require transportation on a stretcher. Transportation must be from the recipient's home to a medical provider for diagnosis or treatment, between medical providers when necessary, or from a medical provider to the recipient's home.

DRIVER QUALIFICATIONS

A wheelchair transportation provider must ensure that the driver providing the transportation service meets the following criteria:

1. Possess a valid South Dakota driver's license for the class of vehicle driven;
2. Be at least 18 years old and have at least one year of experience as a licensed driver;
3. During the previous three years, has not had a conviction of driving under the influence pursuant to SDCL chapter 32-12; 32-23; and
4. Does not have a hearing loss of more than 30 decibels in the better ear with or without a hearing aid. A driver whose hearing meets this minimum requirement only when wearing a hearing aid must wear a hearing aid and have it in operation at all times while driving.

REQUIRED TRAINING FOR DRIVER AND ATTENDANT

A wheelchair transportation provider must ensure that each driver and attendant is able to assist a passenger into and out of a vehicle and that each receives the following training:

1. Before providing services, instruction in the operation of the vehicle ramp, wheelchair lift, and wheelchair securement device;
2. Before providing services, instruction in the procedures to follow in case of a medical emergency or an accident;
3. Before providing services, instruction in the use of the fire extinguisher located in the vehicle used for wheelchair transportation;
4. Before providing services, instruction in the area of passenger sensitivity;
5. Within 45 days after the driver or attendant begins providing services:
    - four hours of training in first aid;
    - including treatment of shock;
    - control of bleeding;
    - airway management;
    - prevention and treatment of frostbite and exposure to cold;
    - prevention and treatment of heat exhaustion and heat stroke; and
    - recognition of sudden illnesses, such as stroke, heart attack, fainting, and seizures.

    This requirement does not apply to a person who possesses a current basic or advanced first aid certification by the American Red Cross or a current certification as an emergency medical technician.
6. Within 45 days after the driver or attendant begins providing services, four hours of classroom instruction in defensive driving; and
7. Within 60 days after the driver or attendant begins providing services:
    - Eight hours of training in moving wheelchairs up and down steps, curbs, ramps, and lifts;
    - Handling a wheelchair on uneven, wet, or icy Surfaces;
    - Folding and unfolding a manual wheelchair;
    - The proper use and operation of the lift, ramp, and wheelchair securement devices; and
    - The functional limitations of the aging process and major disabling conditions and how those conditions affect mobility and communication, including speech, balance, loss of limbs, muscle control, skin sensation, and temperature control, breathing disorders, vision and hearing impairment, and paralysis.

At least once every three years, the provider must ensure that each driver and attendant has completed a refresher course covering those items contained in subdivisions (5) and (6) of this section.

REQUIRED VEHICLE EQUIPMENT

Each vehicle used for wheelchair transportation services must contain the following equipment;

1. A dry chemical fire extinguisher with no less than a 5B:C rating. The extinguisher must have a tag that indicates that it has been serviced within the preceding year. The fire extinguisher must be securely mounted in a bracket and readily accessible to the driver.
2. An emergency first aid kit. The kit must be kept in a dustproof container, labeled “First Aid,” and contain at least six four-inch by four-inch sterile gauze pads, two soft roll bandages, three inches to six inches by five yards, adhesive tape, and scissors;
3. Equipment capable of establishing and maintaining two-way communications, such as a citizen’s band radio or a cellular phone;
4. A working flashlight;
5. A removable, and moisture proof, body fluid clean-up kit;
6. From October 1 to April 30, an ice scraper;
7. A blanket;
8. Three emergency warning triangles. Both faces of each triangle must consist of red reflective and orange fluorescent material. Each of the three sides of the triangular device must be 17 to 22 inches long and two to three inches wide. The warning device must be designed to be erected and replaced in its container without the use of tools. Each device must have instructions for its erection and display. All edges must be rounded or chamfered, as necessary to reduce the possibility of cutting or harming the user. The device must consist entirely of the triangular portion and attachments necessary for its support and enclosure, without additional visible shapes or attachments. The units must be kept clean and in good repair and stored so they are readily available if needed;
9. If the vehicle is equipped with an interior fuse box, extra fuses;
10. If the vehicle carries wheelchairs, securement devices that meet the requirements of ARSD 67:16:25:04.04, and a copy of the manufacturer’s instructions of the proper use of the securement devices;
11. If the vehicle is equipped with wheelchair securement devices, a tool designed and used for cutting a securement strap. The tool must not have an exposed sharp edge or be of a type that could be used as a weapon;
12. If the vehicle is equipped with a ramp, the ramp must have a slip-proof Surface to provide traction. One end of the ramp must be secured to the floor of the vehicle when the ramp is in use.

SECUREMENT DEVICES

A vehicle used for wheelchair transportation must be equipped with a wheelchair securement device and a wheelchair occupant restraint system for each wheelchair and occupant being transported. Each wheelchair securement device must be installed and used according to the manufacturer’s instruction. Each wheelchair occupant restraint system must provide pelvic and upper torso restraint and must comply with the requirements of 49 C.F.R. §517.222, S5.4.1 to S5.4.4, inclusive (October 1, 1997). The driver or the attendant must ensure that the wheelchair occupant restraint system is fastened around the wheelchair user before the driver sets the vehicle in motion.

VEHICLE INSPECTIONS

Each day, before a wheelchair transportation vehicle is used to transport a Medical Assistance Program recipient, the provider must:

- Ensure that the vehicle's coolant, fuel, and windshield washer fluid levels are full;
- The lights, turn signals, hazard flashers, and windshield wipers are operational;
- The tires do not have cuts in the fabric or are not worn so that the fabric is visible, do not have knots or bulges in the sidewall or tread, and have tread which measures at least two thirty-seconds of an inch on any two adjacent tread grooves.

In addition, the provider must ensure that there is a safety inspection of the vehicle once each week or every 1,000 miles, whichever occurs first. The safety inspection must ensure the following:

1. The vehicle's oil and brake fluid levels are maintained at the levels recommended by the manufacturer;
2. The air pressure in the tires is maintained at the levels recommended by the manufacturer;
3. The horn, brakes, and parking brakes are in working order;
4. The instrument panel is fully operational;
5. The fan belt is not worn and in need of replacing;
6. The wheelchair ramp, lift, and lift electrical systems are in working order;
7. The wheelchair securement devices are not damaged and are able to be used to safely restrain the passenger;
8. The passenger heating and cooling systems are in working order; and
9. The emergency doors and windows function properly.

After the safety inspection, any equipment determined to be nonfunctioning or in need of maintenance must be repaired or serviced before transporting a Medical Assistance Program recipient.

Smoking is prohibited in a wheelchair transportation vehicle whenever a Medical Assistance Program recipient is being transported. A "NO SMOKING" sign must be posted in the vehicle so that it is visible to all passengers.

Drivers and passengers must use seatbelts whenever the vehicle is in motion. Before pulling away from a stop, the driver or attendant must instruct the passengers that seatbelt use is required and must make sure the passengers have seatbelts properly secured.

The driver or attendant must ensure that the securement devices and the seatbelt assemblies are retracted, removed, or other wise stored when not in use.

If a vehicle is stopped for an emergency purpose or is disabled on the roadway or shoulder of a highway outside a business or residence district during the time when headlights must be displayed, the driver must place an emergency warning triangle on the traffic side of the road within ten feet from the rear of the vehicle in the direction of traffic approaching in that lane. A second emergency warning triangle must be placed approximately 100 feet from the rear of the vehicle in the direction of traffic approaching in that lane. If the vehicle is stopped or disabled on a one-way road, the driver must place an additional warning triangle approximately 200 feet from the rear of the vehicle in the direction of approaching traffic.

LIABILITY INSURSANCE

At a minimum, the provider must have liability insurance coverage in the amount of $1,000,000 for bodily injury to or death of any person in a single accident. If the policy is written on a single limit basis, the policy must specify that the limit is $1,000,000 for each occurrence.

COMPLAINTS – INSPECTION

If the department receives a complaint concerning the condition of a vehicle used to transport Medical Assistance Program recipients or the vehicle's equipment, the department may inspect or provide for an inspection of the vehicle. The inspection may be unannounced.

If it is determined that the vehicle is in need of repairs, the department shall provide a written notice to the provider detailing the needed repairs or maintenance. The vehicle may not be used to transport Medical Assistance Program recipients until after the repairs are made and the provider has sent written verification to the department that the repairs are made.

Failure to permit an inspection results in the immediate termination of the provider's contract with the department.

If a provider receives a complaint against a driver or an attendant, the provider must investigate the complaint and attempt to resolve the issue. The provider must prepare and maintain a written report that contains a description of the complaint, the results of the investigation, and the action taken, if any.

RECORD RETENTION

A provider must maintain the following written documents and must make them available to the department on request:

1. The dates each of the requirements contained in ARSD 67:16:25:04.01 and 67:16:25:04.02 were verified by the provider;
2. A statement signed and dated by the provider which verifies that each vehicle used for wheelchair transportation contains the equipment required in ARSD 67:16:25:04.03;
3. A statement signed and dated by the provider which verifies that the wheelchair securement devices meet the requirements of ARSD 67:16:04.04;
4. A record of the safety inspections conducted under ARSD 67:16:25:04.05. The record must contain the date of the inspection, the odometer reading, the result of the inspection, and a notation of the repairs needed;

5. The service records for each vehicle and wheelchair lift indicating the date, the odometer reading, and the nature of the maintenance work performed;
6. A statement from the insurance carrier that verifies that each vehicle used to transport South Dakota Medical Program recipients has insurance which meets or exceeds the requirements established in ARSD 67:16:25:04.06;
7. The accident records of each vehicle involved in an accident; and
8. A record of complaints received and a statement describing how the provider responded to each complaint.

PROCEDURE CODES AND PRICES

A company, firm, or individual that uses specifically designed and equipped vehicles to provide non-emergency transportation to and from medical care for Medical Assistance

Program recipients confined to wheelchairs or requiring transportation on a stretcher procedure codes and prices are found in ARSD 67:16:25:05.
If more than one Medical Assistance Program recipient is aboard for any portion of the trip, procedure codes are found in ARSD 67:16:25:05 must be used in billing for each Medical Assistance Program recipient.

To be eligible for hospital transfer a recipient must have been discharged from an inpatient hospital stay.

Mileage may only be claimed for trips outside the city limits. To be eligible for loaded mileage for trips outside the city limits, the provider must have legal authority to operate outside the city limits.

Payment for wheelchair transportation services outside the city limits includes the applicable trip fee as indicated in ARSD 67:16:25.05 and loaded mileage calculated from the point the trip goes outside the city limits to the destination, limited to 100 miles or stated amount in ARSD 67:16:25:05 per recipient per day. Only one mileage allowance is payable for each trip regardless of the number of passengers.

COMMUNITY TRANSPORTATION SERVICES

PROVIDER CRITERIA

A community transportation provider must be a governmental entity or registered as a nonprofit organization with the South Dakota secretary of state. The organization or entity must have a signed transportation provider agreement with the department to furnish non-emergency medical transportation to Medical Assistance Program recipients.

PROCEDURE CODES AND PRICES

The prices listed in Administrative Rule of South Dakota (ARSD) 67:16:25:07.01 are subject to change without prior change of this manual.

To be eligible for loaded mileage for trips outside city limits, the trip must be more than 25 miles.

Payment for community transportation services outside city limits includes the applicable trip fee as indicated in ARSD 67:16:25:07.01

CHAPTER XIV

REMITTANCE ADVICE

The Remittance Advice serves as the Explanation of Benefits (EOB) from the Medical Assistance Program. The purpose of this chapter is to familiarize the provider with the design and content of the Remittance Advice. The importance of understanding and using this document cannot be stressed enough. The current status of all claims, (including Replacements and voids) that have been processed during the past week are shown on the Remittance Advice. **It is the provider's responsibility to reconcile this document with patient records.** The Remittance Advice documents all payments and denials of claims and should be maintained for six years, pursuant to SDCL 22-45-6.

EACH CLAIM LINE IS PROCESSED SEPARATELY

Use the correct reference number (see chapter 1) to ensure that you correctly follow each line of a claim. The following information explains the Remittance Advice format:

HEADER INFORMATION

- Medical Assistance Program Department address and page number;
- Type of Remittance Advice (e.g. nursing home, physician, pharmacy, crossover, etc.) and date;
- Provider name, address, and Medical Assistance Program provider ID number.

REMITTANCE ADVICE FORMAT

Only the last nine (9) digits of the recipient's 14 digit identification number are displayed.

MESSAGES:

The Remittance Advice is used to communicate special information to providers. Policy changes, service limitations, and billing problems are examples of messages that may be published in this section. **READ CAREFULLY ALL MATERIAL PRINTED IN THESE MESSAGES AND ENSURSE THAT THE APPROPRIATE STAFF RECEIVES A COPY OF THE MESSAGE.**

THE FOLLOWING CLAIMS ARE APPROVED ORIGINALS:

Approved (paid): A claim is approved (paid) if it is completely and correctly prepared for a Medical Assistance Program covered service(s) provided to an eligible recipient by a Medical Assistance Program enrolled provider. Claims that have been determined payable are listed in this section with the amount paid by Medical Assistance Program.

THE FOLLOWING CLAIMS ARE DEBIT REPLACEMENTS:
A replacement can be processed only for a claim that has previously been paid. When replacing a claim, resubmit the complete original claim with the corrections included or deleted as appropriate.

NOTE: Once you have replaced a claim you cannot replace or void the original claim again.

THE FOLLOWING CLAIMS ARE CREDIT REPLACEMENTS:
This is the other half of the replacement process. The reference number represents the **original paid claim**. Information in this section reflects the Medical Assistance Program processing of the original paid claim. This information is being replaced by the correct information, listed in the section above (THE FOLLOWING CLAIMS ARE DEBIT REPLACEMENTS:).

THE FOLLOWING CLAIMS ARE VOID:
This section subtracts claims that should not have been paid. The first reference number represents the **voided claim.** The second reference number represents the **original paid claim**(the claim that is being voided). Transactions on this line show a negative amount for the provider.

NOTE: Once you have voided a claim, you cannot void or adjust the same claim again.

CLAIM TOTAL – See Remittance Total below.

THE FOLLOWING CLAIMS ARE DENIED:
A claim is denied if one or more of the following conditions exist:

- The service is not covered by the Medical Assistance Program;
- The claim is not completed properly;
- The claim is a duplicate of a prior claim;
- The data is invalid or logically inconsistent;
- Program limitations or restrictions are exceeded;
- The services is not medically necessary or reasonable; and
- The patient and/or provider is not eligible during the service period.

Providers should review denied claims and, where appropriate, completely resubmit the claim with corrections. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or the Medical Assistance Program policy.

Claims that cannot be paid by Medical Assistance Program are listed in this section. Even though there may be several reasons why a claim cannot be paid, only one denial reason will be listed.

ADD-PAY/RECOVERY REASONS: MISCELLANEOUS
When an adjustment or void has not produced a correct payment, a lump sum **payment or deduction** is processed. There is no identifying information on the Remittance Advice about what recipient or services this payment is made for. A letter is sent to the provider explaining the add-pay/recovery information. If the amount is to be subtracted from the provider there will be a minus sign behind the amount; Otherwise the amount is a payment to the provider.

REMITTANCE TOTAL

The total amount is determined by adding and subtracting all of the amounts listed under the column **PAID BY PROGRAM.**

YTD NEGATIVE BALANCE

A Year-to Date (YTD) negative balance is posted in one of two situations. When ONLY void claims are processed in a payment cycle for the provider and no original paid claims are included on the Remittance Advice, a negative balance is displayed. When the **total amount** of the negative transactions, such as credit replacement and void claims, is larger than the total amount of positive transactions (original paid and debit replacements), a negative balance will be shown.

MMIS REMIT NO ACH AMOUNT OF CHECK

The system produces a sequential Remittance Advice number that is used internally for finance purposes and relates to the check/ACH issue to the provider. The net check amount is the **REMITTANCE TOTAL** minus the **YTD NEGATIVE BALANCE.**

PENDED CLAIMS – THE FOLLOWING CLAIMS ARE PENDED FOR REVIEW – PROVIDER DOES NOT NEED TO TAKE ACTION UNLESS FURTHER CONTACT IS MADE:

A claim that cannot be automatically paid or denied through the normal processing system is pended until the necessary corrective action has been taken. Claims may be pended for erroneous information, incomplete information, information mismatch between the claim and the state master file, or a policy requirement for special review of the claim. The reason for pending the claim is printed on the Remittance Advice. The provider should wait for claim payment or denial before resubmitting the claim.

After a pended claim has been approved for further processing, it is reprocessed and appears on the subsequent Remittance Advice as an approved original either as a paid or a denied claim.

DO NOT SUBMIT A NEW CLAIM FOR A CLAIM IN PENDED STATUS, UNLESS YOU ARE ADVISED BY THE DEPARTMENT TO DO SO.

IF ERRORS ARE IDENTIFIED ON THE REMITTANCE ADVICE, PLEASE NOTIFY THE MEDICAL ASSISTANCE PROGRAM AT 1-800-452-7691 AS SOON AS POSSIBLE.

CHAPTER XV

COST SHARING

Eligible Medical Assistance Program recipients who are under 19 years of age, a resident in a long term care facility, or under the Home and Community Based Services program are **NOT** required to participate in the cost of medical care.

The following services **DO NOT** require the recipient to pay a cost share:

1. Emergency inpatient hospital care;
2. Emergency outpatient hospital care;
3. Family planning;
4. Pregnancy related;
5. Home health;
6. Transportation;
7. Nutritional therapy/supplementation (under the age of 21);
8. School District Services;
9. Nursing facility residents;
10. Psychiatric inpatient and rehabilitation.

The following services **DO** require the recipient to pay a cost share:

1. Physician and other health services covered under 67:16:02:11;
   a. $3 for each procedure billed by a physician as a charge for an office visit, visit to a patient's home, admission to a hospital, medical psychotherapy, or general ophthalmological service; and
   b. Five percent of the allowable reimbursement for each item of medical equipment or each prosthetic device billed whether provided by a physician or other supplier.

2. Inpatient hospital not billed as emergencies is $50 per admission.

3. Outpatient hospital services and ambulatory surgical centers not billed as emergencies is 5% of the allowable medical Assistance Program reimbursement up to a maximum of $50.

4. Prescriptions - $3 for each brand name prescription filled or refilled. There is no cost share on generic medications.

5. Dental services;
   a. $3 for each procedure other than dentures or relining of dentures;
   b. $3 for each denture; and
   c. $3 for each relining of a denture.

6. Podiatry services, $2 for each covered procedure.

7. Covered chiropractic services listed in §67:16:09:05.01 is $1.00 for each procedure billed using codes A2000, W8600, or W8620. Cost share is not applied to radiological examination procedure codes.

8. Optometric and optical services as follows:
   a. $2 for each procedure;
   b. $2 for each lens charge;
   c. $2 for each frame charge;
   d. $2 for other parts; and
   e. $2 for repair service.

9. EPSDT services provided to individuals 19 years of age and over on the date of the service is as follows:
   a. $3 for each screening;
   b. $3 for each dental procedure;
   c. $3 for dentures;
   d. $2 for each optometric or optical procedure.

10. Nutritional Services (age 21 and older):
    a. $2 a day for enteral;
    b. $5 a day for parenteral.

11. Diabetes Education - $3 per unit of service.

12. Chemical Dependency Treatment (age 19 to 21) - Co-pay may be required.

13. Rural Health Clinics and Federally Qualified Health Centers - $3 each visit at facility or hospital-based clinic.

14. Mental Health Clinics - Five percent of the allowable reimbursement for each procedure.

CHAPTER XVI

BILLING INSTRUCTIONS

The following instructions apply to paper claims only.

HCFA 1500 CLAIM FORM

The HCFA 1500 form substantially meets the requirements for filing covered physician services. It has been designed to permit billing for up to six services for one recipient.

The South Dakota Medical Assistance Program does not provide this form. These forms are available for direct purchases through either of the following agencies.

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402
(202) 512-1800 (pricing desk)

OR

American Medical Association
P O Box 10946
Chicago, IL 60610
ATTN: Order Department

If you prefer to have your own forms printed, negatives and reproducibles are available from:

Government Printing Office
Room C836, Building 3
Washington, DC 20401

CODES

The procedure codes allowed for filing covered practitioner services are found in the most current CPT and HCPC manuals.

SUBMISSION

The original filing of claims must be within 12 months of the date of service, unless third party liability insurance is involved or initial retroactive eligibility is determined as listed in ARSD 67:16:35:04.

A provider may only submit a claim for services the provider knows or should have known are covered by the Medical Assistance Program.

A claim must be submitted at the provider's usual and customary charge for the service, on the date the service was provided.

The name that appears on the Remittance Advice indicates the provider name that the Medical Assistance Program associates with the assigned provider number. This name must correspond with the name submitted on claims.

Failure to properly complete provider name and address as enrolled with the South Dakota Medical Assistance Program could be cause for non-processing or denial of the claim by the Medical Assistance Program.

The original HCFA 1500 claim form is to be submitted to the address listed below. The copy should be retained for your records.

Department of Social Services
Office of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

The provider is responsible for the proper postage

HOW TO COMPLETE THE HCFA 1500 CLAIM FORM

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by the Medical Assistance Program.

THE FOLLOWING IS A BLOCK BY BLOCK EXPLANATION OF HOW TO PREPARE THE HEALTH INSURSANCE CLAIM FORM HCFA 1500.

Please do not write or type above block 1 of the claim form. It is used by the South Dakota Medical Assistance Program for control numbering.

BLOCK 1 HEADINGS
Place an "X" or check mark in the Medicaid block. If left blank, Medicaid (Medical Assistance Program) will be considered the applicable program.

BLOCK 1a INSURED'S ID NO. (*MANDATORY*)
The recipient identification number is the nine-digit number found on the South Dakota Medical Assistance Program Identification Card. **The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.**

BLOCK 2 **PATIENT'S NAME (*MANDATORY*)**
Enter the recipient's last name, first name, and middle initial.

BLOCK 3 PATIENT'S DATE OF BIRTH
If available, please enter in this format. MM-DD-YY.

PATIENT'S SEX
Optional

BLOCK 4 INSURED'S NAME
Optional

BLOCK 5 PATIENT'S ADDRESS
Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

BLOCK 9 **OTHER INSURED'S NAME (*MANDATORY*)**
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, 9d, if known.

NOTE: Do not enter Medicare, PHS, or IHS

BLOCK 10 WAS CONDITION RELATED TO

A Patient's Employment-If the patient was treated due to employment-related accident, place an "X" in the YES block, if not, place an "X" in the NO block or leave blank.

B/C Accident-If the patient was treated due to an auto accident, place an "X" in the appropriate block. If other type of accident, place an "X" in the OTHER block and explain. If not an accident, leave blank.

D Reserved For Local Use-Enter one of the following, if applicable: "**U**" for Urgent Care; "**I**" for Contract Providers; "**D**" for Dental Services; or "**E**" for Emergent Managed Care Exemption Code.

BLOCK 11 **INSURED'S POLICY GROUP OR FECA NUMBER(*MANDATORY)***
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check "YES" block 11d. If "YES" is checked in block 11d, provide the requested information in blocks 9, 9a, 9b, 9c, 9d, if known.

BLOCK 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 14 DATE OF CURRENT ILLNESS
Optional

BLOCK 15 IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional

BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
If the recipient was a referral, enter the referring physician's or (other sources) name. Optional, but very helpful.

BLOCK 17a ID NUMBER OF REFERRING PHYSICIAN
If recipient was a referral, enter the referring physician's or (other sources) provider number. This is ***mandatory*** for Managed Care recipients not treated by their PCP.

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19 RESERVED FOR LOCAL USE
Not applicable, leave blank.

BLOCK 20 OUTSIDE LAB
Place an "X" in the "YES" or "NO" block. Leave the space following "Charges" blank. If not applicable, leave blank.

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
Diagnosis codes and descriptions 1, 2, 3, and 4 – Enter the appropriate diagnosis code(s) which best describe the reason(s) for treatment or service, listing the primary in position "1", secondary in position "2", etc.
These codes must be ICD-9 codes. "V" codes are acceptable.
"E" codes are not used by the South Dakota Medical Assistance Program.
The following claims are exempt from diagnosis code requirements:

1. Anesthesia;
2. Ambulatory Surgical Center;
3. Audiology;
4. Durable Medical Equipment;
5. Laboratory or pathology;
6. Therapy Services;
7. Radiology;
8. School Districts; and
9. Transportation.

BLOCK 22 MEDICAID RESUBMISSION NUMBER
Required for replacements and voids only.

BLOCK 23 PRIOR AUTHORIZATION NUMBER
Enter the prior authorization number provided by the department, if applicable.

NOTE: Leave blank if the South Dakota Medical Assistance Program does not require prior authorization for service.

BLOCK 24 Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form for the seventh and following services must be completed.

A **DATE OF SERVICE FROM – TO (*MANDATORY)***
Enter the appropriate date of service in month, day, and year sequence, using six digits.

	FROM	TO
Example:	01/24/04	01/24/04

B **PLACE OF SERVICE (*MANDATORY)***
Enter the appropriate place of service code.
Code values:

11	Office
12	Home
21	Inpatient hospital
22	Outpatient hospital
23	Emergency Room-Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance-Land
42	Ambulance-Air or Water
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

C LEAVE BLANK

D **PROCEDURE CODE (*MANDATORY)***
Enter the appropriate five character HCFA Common Procedure Coding System (HCPC) or CPT procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable.
NOTE: Use the same procedure code only once per date of service.

E DIAGNOSIS CODE
Optional – you may enter codes as entered in Block 21.

F **CHARGES *(MANDATORY)***
Enter the provider's usual and customary charge for this service or procedure.

G **DAYS OR UNITS *(MANDATORY) (if more than one)***
Enter the number of units or times that the procedure or service was provided for this recipient during the period covered by the dates in block 24a. If this is left blank, reimbursement will be for one unit/time (15 minutes).

H EPSDT – FAMILY PLANNING
Early and Periodic Screening, Diagnosis and Treatment. If services were provided because of an EPSDT referral, enter an "E", if not, leave blank.

FAMILY PLANNING
Enter an "F" for any service provided for family planning medication, devices, or Surgical procedures.

I EMG
Not applicable, leave blank.

J COB
Not applicable, leave blank.

K LEAVE BLANK – EXCEPT FOR GROUP PROVIDERS
Group providers approved by the South Dakota Medical Assistance Program, enter the seven digit Medical Assistance Program provider number of the physician providing the care or service. All other providers leave blank.

BLOCK 25 FEDERAL TAX ID NUMBER
Optional

BLOCK 26 YOUR PATIENT'S ACCOUNT NO.
Enter your office's patient account number, up to ten numbers, letters, or a combination thereof is allowable.

Examples: AMX2345765, 9873546210 and YNXDABNMLK

NOTE: Block 26 optional, included for your convenience only. Information entered here will appear on your Remittance Advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT
Not applicable, leave blank.

NOTE: The South Dakota Medical Assistance Program can only pay the provider, not the recipient of medical care.

BLOCK 28 TOTAL CHARGES
Optional

BLOCK 29 AMOUNT PAID *(MANDATORY)*
If payment was received from private health insurance, enter the amount received here. (Attach a copy of the Insurance Company's Remittance Advice or explanation of benefits behind each claim form.) The Office of Medical Services will allocate that payment to each individual line of service as necessary. If payment was denied, enter 0.00 here (attach a copy of insurance company's denial).

NOTE 1: Do not subtract the other insurance from your charge.

NOTE 2: Medicaid's Cost Sharing (recipient's payment), if applicable is not considered a payment from other source – do not enter on claim.

BLOCK 30 BALANCE DUE
Optional

BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER *(MANDATORY)*
The invoice must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. **Claims will not be paid without signature and date completed.**

BLOCK 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
Optional

BLOCK 33 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. *(MANDATORY)*
Enter the billing provider's name as listed on the South Dakota Medical Assistance Program Provider file with the complete address. The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

ID NO. *(MANDATORY)*
Enter your seven-digit Provider Identification Number, which was assigned by the South Dakota Medical Assistance Program.

SUBMITTING VOID AND REPLACEMENT REQUESTS

Claim level processing links all lines of a claim for purposes of posting and reporting. Each line is evaluated separately for payment, but the lines are all reported under a single claim reference number. In other words, all lines submitted on a single claim form will have a single claim reference number assigned to them.

The necessary processing is described in detail below. We believe these procedures will result in less work for your staff and quicker processing though the Medical Assistance Program claims payment system.

VOID REQUEST

A void request instructs the Medical Assistance Program to reverse all the money paid on a claim. Every line is reprocessed. A paid line has the payment reversed. A denied line remains denied. A pending line is denied. The transaction is shown on your Remittance Advice as a payment deduction from payment that may be due you.

To submit a void request, follow the steps below:

- Make a copy of your paid claim;
- In field 22, enter the word “VOID” at the left;
- In the same field, enter the claim reference number that the Medical Assistance Program assigned to the original claim, at the right;
- Highlight field 22;
- Send the void request to the same address you have always used; and
- Keep a copy of your request for your files.

If the original claim reference number is not shown in the void request, it will not be processed, and will appear on your Remittance Advice as an error.
Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

REPLACEMENT REQUEST

A replacement request consists of two steps. First, a credit adjustment, or void is generated by the claims payment system, for each line on the original claim and processed. This part of the transaction works as described in void processing, above. The corrections you supply are entered and the entire claim is reprocessed. A paid line can be increased or decreased. A denied line remains denied, and a pended line is also denied. The replacement claim may include more or fewer lines than the original. The transaction is shown on your Remittance Advice and changes in payment are added to or deducted from any payment that may be due to you.

To submit a replacement request, follow the steps below:

- Make a copy of your paid claim;
- In field 22, enter the word **REPLACEMENT** at the left;
- In the same field, enter the claim reference number that the Medical Assistance Program assigned to the original claim, at the right;

- Highlight field 22;
- Indicate corrections to the claim by striking through incorrect information and entering corrections. You may use correction fluid or tape to remove incorrect information and replace with correct information;
- Highlight all the corrections you have entered;
- **Do not** attach additional separate pages or use post-it notes. These may become separated from your request and delay processing;
- Send your replacement request to the same address you have always used; and
- Keep a copy of your request for your files.

An original claim can be replaced only once. You may, however, submit a void or replacement request for a previously completed replacement. In this case, enter VOID or REPLACEMENT (as appropriate) in field 22 at the right and indicate the claim reference number of the replacement claim at the left. Highlight field 22, enter and highlight any corrections, as described above, and submit your request.

The Medical Assistance Program claims payment system links the original claim with subsequent replacement and/or void requests, to ensure that any transaction is only replaced or voided once.

CROSSOVER CLAIM SUBMISSION

The HCFA 1500 claim form substantially meets the requirements for filing claims for services for recipients who are dually eligible for both the Medical Assistance Program and Medicare after Medicare has determined a deductible or co-insurance amount is due.

SUBMISSION

The original filing of services must be within 12 months of the date of service, unless third party liability insurance is involved or initial retroactive eligibility is determined.

The name that appears on the Remittance Advice indicates the provider name the Medical Assistance Program associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

Failure to properly complete provider name and address as registered with the South Dakota Medical Assistance Program could be cause for non-processing or denial of the claim by the Medical Assistance Program.

Because the Medical Assistance Program is the payer of last resort you must submit your claim to Medicare first. You must submit a crossover claim to the Medical Assistance Program when billing for the Medicare co-insurance and/or deductible. Proof of payment from Medicare (EOMB, voucher, etc.) must be attached to the crossover claim form.

DO NOT submit a crossover claim form if Medicare has denied payment.

The South Dakota Medical Assistance Program will not pay for any service that has been denied by Medicare as <u>not medically necessary or reasonable</u>. If Medicare's denial was for another reason, you may submit a HCFA claim form along with a copy of the Explanation of Medicare Benefits (EOMB for consideration of payment.

The crossover claim is to be submitted to the address below. A copy is to be retained for your records.

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for the proper postage.

HOW TO COMPLETE THE MEDICARE CROSSOVER CLAIM ON THE HCFA 1500 CLAIM FORM

MANDATORY:
The provider **MUST** attach the EOMB and any applicable third party explanation of benefits (EOB) to **EACH** crossover claim form. Crossover claims **cannot** be processed without an EOMB.

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by the Medical Assistance Program.

THE FOLLOWING IS A BLOCK BY BLOCK EXPLANATION OF HOW TO PREPARE THE MEDICARE CROSSOVER CLAIM ON THE HEALTH INSURSANCE CLAIM FORM HCFA 1500.

Please do not write or type above block 1 of the claim form. It is used by South Dakota Medical Assistance Program for control numbering.

BLOCK 1 **HEADINGS**
Place an "X" or check mark in the Medicare block. If left blank, Medicaid (Medical Assistance Program) will be considered the applicable program.

BLOCK 1a **INSURED'S ID NO. (*MANDATORY*)**
The recipient identification number is the nine-digit number found on the South Dakota Medical Assistance Program Identification Card. **The three-digit generation number, that follows the nine-digit recipient number, is not part of the recipient's ID number and should not be entered on the claim.**

BLOCK 2 **PATIENT'S NAME (*MANDATORY*)**
Enter the recipient's last name, first name, and middle initial.

BLOCK 3 PATIENT'S DATE OF BIRTH
If available, please enter in this format. MM-DD-YY.

PATIENT'S SEX
Optional

BLOCK 4 INSURED'S NAME
Optional

BLOCK 5 PATIENT'S ADDRESS

Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

BLOCK 9 OTHER INSURED'S NAME (*MANDATORY*)
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, 9d, if known.

BLOCK 10 WAS CONDITION RELATED TO
Not used for Medicare Crossover Claims

BLOCK 11 INSURED'S POLICY GROUP OR FECA NUMBER(*MANDATORY)*
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check "YES" Block 11d. If "YES" is checked in Block 11d, provide the requested information in Blocks 9, 9a, 9b, 9c, 9d, if known.

BLOCK 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 14 DATE OF CURRENT ILLNESS
Optional

BLOCK 15 IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional

BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
Optional for Medicare crossover claims

BLOCK 17a ID NUMBER OF REFERRING PHYSICIAN
Optional for Medicare crossover claims

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19 RESERVED FOR LOCAL USE

Not applicable, leave blank.

BLOCK 20 OUTSIDE LAB
Optional for Medicare crossover claims

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
Not required for Medicare crossover claims:

BLOCK 22 MEDICAID RESUBMISSION NUMBER
Not applicable leave blank

BLOCK 23 PRIOR AUTHORIZATION NUMBER
Optional for Medicare crossover claims

BLOCK 24 Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form must be completed for the seventh and following services.

A **DATE OF SERVICE FROM – TO (*MANDATORY)***
Enter the appropriate date of service in month, day, and year sequence, using six digits.

B **PLACE OF SERVICE (*MANDATORY)***
Enter the appropriate place of service code.

C TOS (TYPE OF SERVICE)
Optional – you may enter the appropriate type of service.

D **PROCEDURE CODE (*MANDATORY)***
Enter the appropriate five character HCFA Common Procedure Coding System (HCPC) procedure code for the service provided. Enter the appropriate procedure modifier, if applicable.

NOTE: Use the same procedure code only once per date of service.

E DIAGNOSIS CODE
Not required for Medicare crossover claims

F **CHARGES *(MANDATORY)***
Enter your usual and customary charges billed to Medicare

G DAYS OR UNITS
Not used for Medicare crossover claims

H EPSDT – FAMILY PLANNING
Not used for Medicare crossover claims

FAMILY PLANNING
Not used for Medicare crossover claims

I EMG
Not applicable, leave blank.

J COB
Not applicable, leave blank.

K MEDICARE CROSSOVER CLAIMS *(MANDATORY)*
Enter the provider paid amount plus any contractual adjustment and any other third party payment for each line of service on the HCFA 1500 claim form.

BLOCK 25 FEDERAL TAX ID NUMBER
Optional

BLOCK 26 YOUR PATIENT'S ACCOUNT NO.
Enter your office's patient account number, up to ten numbers, letters, or a combination thereof is allowable.

BLOCK 27 ACCEPT ASSIGNMENT
Not applicable, leave blank.

BLOCK 28 TOTAL CHARGES
Optional

BLOCK 29 AMOUNT PAID *(MANDATORY)*
Enter **TOTAL** amount paid by other payer including Medicare

BLOCK 30 BALANCE DUE
Enter Medicare coinsurance and/or deductible due

BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER *(MANDATORY)*
The invoice must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. **Claims will not be paid without signature and date completed.**

BLOCK 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
Optional

BLOCK 33 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. *(MANDATORY)*
Enter the billing provider's name as listed on the South Dakota Medical Assistance Program Provider file with complete address. The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

ID NO. *(MANDATORY)*
Enter your seven-digit Provider Identification Number, which was assigned by the South Dakota Medical Assistance Program.

IMPORTANT NOTE FOR GROUP PROVIDERS:

You must enter the seven digit South Dakota Medical Assistance provider identification number of the servicing provider at PIN # location. Also enter GRP # as indicated.

CHAPTER XVII

ADMINISTRATIVE RULE

The following Administrative Rules of South Dakota may be found by clicking on the appropriate chapter number below.

AMBULATORY SURGICAL CENTERS (ASC) 67:16:28

CHIROPRACTIC 67:16:09

CLAIMS 67:16:35

DURABLE MEDICAL EQUIPMENT 67:16:29

EPSDT 67:16:11

GENERAL PROVISIONS 67:16:01

MANAGED CARE 67:16:39

MENTAL HEALTH SERVICES BY INDEPENDENT PRACTIONERS 67:16:41

OPTOMETRIC AND OPTICAL SERVICES 67:16:08

PHYSICIAN 67:16:02

PODIATRY 67:16:07

PROVIDER ENROLLMENT 67:16:33

RECORDS 67:16:34

SCHOOL DISTRICT 67:16:37

THIRD-PARTY LIABILITY 67:16:26

TRANSPORTATION SERVICES 67:16:25